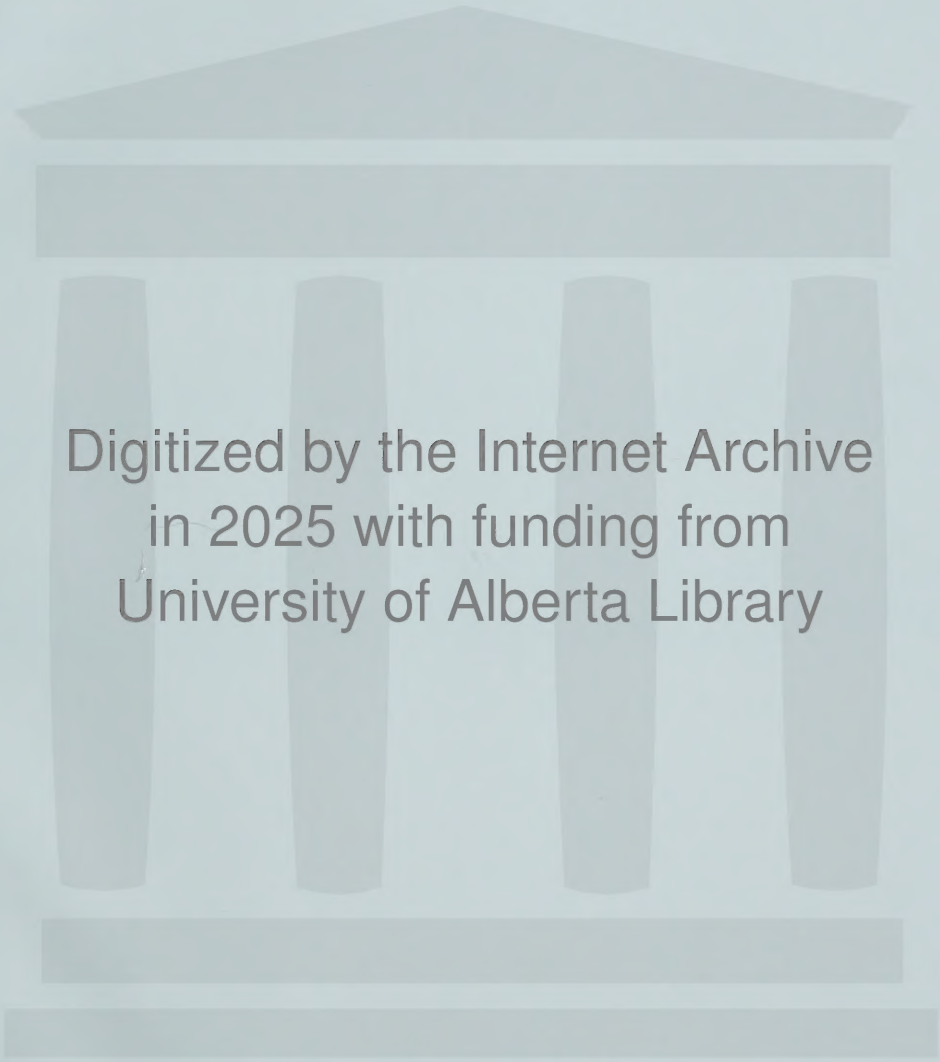

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Concept Analysis of Preceptorship

by

Diane B. Wilson Billay

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Master of Nursing

Faculty of Nursing

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Faculty of Graduate Studies and Research

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled **Concept Analysis of Preceptorship** submitted by Diane B. Wilson Billay in partial fulfillment of the requirements for the degree of Master of Nursing.

Abstract

The purpose of this study is to develop a beginning model and propositional statements about the nature of the concept of preceptorship. This was done through a theoretical analysis of the nursing and related literature in which the existing literature directly and indirectly related to the topic of preceptorship was searched, analysed, and reconceptualised. Data were collected from the literature on nursing, education, medicine, rehabilitation, law, pharmacy, dentistry, clinical psychology, and social work. The findings from this study may be used to assist nurses to understand the importance of preceptorship in terms of facilitating neophyte nursing students and new staff members. The implications are as follows: developing policy in terms of preceptorship programs, ensuring the consistent preparation and selection of preceptors, and defining preceptorship.

Acknowledgements

I would like to acknowledge the assistance of my supervisor, Dr. Olive Yonge, in the process of completing this research. My sincere gratitude goes to Dr. Yonge, who in introducing me to the process of theoretical analysis in nursing has generously shared her time. Her enthusiasm has been encouraging and has helped me extend my personal and professional knowledge regarding preceptorship. I am grateful for her patience, humour, challenging questions, and perceptiveness, which were important assets in challenging my thinking about nursing practice and guiding this research. I also wish to thank Drs. Paul Hagler and Brenda Cameron, my committee members, for their valuable suggestions and support during the course of this research.

I extend my deepest gratitude to my husband Byron, and to my immediate family, friends, and nursing colleagues who made a major contribution to my research by actively listening, questioning, and encouraging me. To my friend and mentor Margie Olsen: God bless you. In addition, I would like to thank Mr. and Mrs. R. Wilson for their initial editing of this thesis.

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CHAPTER I

INTRODUCTION

Purpose of the Study

The purpose of this study was to develop a beginning model and propositional statements about the nature of the concept of preceptorship. This was done through a theoretical analysis of the nursing and related literature in which the existing literature directly and indirectly related to the topic of preceptorship was searched, analysed, and reconceptualized. The findings from this study may be used to assist nurses to understand the importance of preceptorship in terms of facilitating neophyte nursing students and new staff members.

Research Questions

The central question guiding this study was: "What is the concept of preceptorship?" Related subquestions guiding the literature search and the analysis were as follows:

1. What are the most applicable definitions of preceptorship?
2. What is the function or purpose of preceptorship?
3. How are preceptors prepared for a preceptee?
4. How are preceptors evaluated?
5. How are preceptors rewarded?
6. How do faculty support preceptors?
7. What are the related concepts that contribute to the definition of preceptorship?
8. What is the relationship of other teaching areas such as clinical teaching, mentoring, and boundaries to preceptorship?

This thesis is presented as a journey of development and discovery from an explanation of the original concept, a more general discussion of the possibilities and

problems in defining the characteristics and attributes of preceptorship, to the final stage, a theoretical model of preceptorship. The method of knowledge development and concept synthesis was through a theoretical analysis of the nursing and associated disciplines' literature.

Definitions

There are six definitions deemed relevant to this research, which are as follows:

Concept analysis: A "careful examination and description of a word and its uses in the language coupled with an explanation of how it is "like" and "not like" other related words" (Walker & Avant, 1995, p. 38).

Faculty: A professor or educator at a university or college who develops, monitors, maintains, and evaluates the quality of the preceptorship experience. This individual is accountable for student education, supports preceptors and students throughout the experience, and evaluates the student at the end of the experience (Schoener & Garrett, 1996).

Preceptee: A (neophyte nurse or) student engaged in learning the role of the nurse from an experienced staff nurse or preceptor (Kaviani & Stillwell, 2000).

Preceptor: An experienced nursing professional who teaches, supervises, and serves as a role model for a student or graduate nurse, for a prearranged period of time, in a formalised programme (Usher, Nolan, Reser, Owens, & Tollefson, 1999).

Preceptorship:

> Involves access to an experienced and competent role model and a means of building a supportive one-to-one teaching and learning relationship. This relationship tends to be short-term [and is aimed at] assisting the newly qualified practitioner or nursing student to adjust to the nursing role. (Kaviani & Stillwell, 2000, p. 219)

Boundary: "Those lines which separate therapeutic behaviour of a professional from behaviour which, whether well intentioned or not, could detract from achievable health outcomes for patients and clients receiving nursing care" (Alberta Association of

Registered Nurses, 1998, p. 29). Boundary theory also applies to the relationship between the preceptor and the preceptee.

Significance

The concept of preceptorship is highly significant for several reasons:

1. Nursing has had a very long and illustrious history of clarifying and developing its knowledge base. In clarifying the concept of preceptorship, a stronger conceptual foundation of this term will be developed, thereby adding to the epistemic foundation of the nursing profession.
2. The term preceptorship is widely used in many health professions—for example, nursing, medicine, and pharmacy—but it is also referred to as supervision, clinical education, and clinical supervision.
3. Preceptorship is commonly used to prepare new staff and students for their new role.

The Alberta Area Health Education Partnership Program (AAHEPP) was a task force established in September 1998 and based at the University of Alberta. The purpose of AAHEPP was to promote greater information sharing between stakeholders to provide improved quality of health services and education, be a resource for partners, broker the service and education needs of its stakeholders, and provide leadership and advocacy for stakeholders. This task force emphasised a rural focus and addressed clinical placements, continuing education, and workforce planning. AAHEPP's partners included 17 postsecondary institutions, 19 regional health authorities and provincial boards, Alberta Health and Wellness, and Alberta Learning.

The AAHEPP (1999) reported on its Survey of Student Clinical Placements in Alberta. In 1999 AAHEPP surveyed preceptorship participants in undergraduate programs in nursing, rehabilitation, medicine, pharmacy, prehospital, allied health, and health care aides/clerks. The number of preceptors utilised varied greatly: nursing,

40,392; rehabilitation, 6,553; medicine, 8,030; pharmacy, 3,120; prehospital, 4,199; allied health, 14,754; and health care aides/clerks, 1,791. These numbers certainly identified the need for preceptors. However, the following questions remained: How are these preceptors prepared? How do faculties support them? Who evaluates the student? Are they appropriately rewarded? In a rough count of all the health science programs, AAHEPP estimated that over 100,000 student weeks were currently being used for preceptorship in the province. It was estimated that if a preceptor spent 5 hours/week with a student, it could be assumed that over 500,000 staff hours were used in preceptoring students. With this phenomenal amount of time and energy involved, a preceptor would have to be adequately prepared academically and emotionally.

The AAHEPP (1999) report pointed out that there are three types of students who need preceptors: beginning-level, senior-level, and postgraduate. It was perceived that "better" students required less education and involvement by a preceptor, whereas "problem students" required more of a preceptor's time and energy. In effect, this latter situation was an inhibitor to becoming a preceptor. One view in the task force's report was that funding should be tied to education (of preceptors) and not distributed into services (adding more staff who would then take on the role of preceptor but who would not necessarily be academically and emotionally prepared for the role). AAHEPP recommended working to clarify the primary question as to who is responsible for educating preceptors.

CHAPTER II

CONCEPT CLARIFICATION

The profession of nursing constantly strives to find meaning and logic in and of itself. Knowledge is the ultimate goal for nurses, whether nurses are in the academic realm or nursing at the bedside. In this chapter are examples of research that used the method of concept analysis, and it lays the foundation for the use of the model of concept analysis detailed by Walker and Avant (1995). When concept analysis is used, rigorous steps are undertaken to establish the meaning of ill-defined or ambiguous concepts; nurses need to know what something is or is not.

The nursing literature is full of scholarly evidence that concept analysis significantly contributes to exploring domains that are relevant and important to the profession of nursing. Pertinent topics include clinical supervision, nurse autonomy, and countertransference. Lyth (2000) performed a concept analysis on clinical supervision. Although it was believed that clinical supervision appeared to be a "good thing," many were unsure what clinical supervision was and what the expectations were. Lyth contended that there was a plethora of models of supervision and definitions, but the concept remained ill defined.

Using Walker and Avant's (1995) model for concept analysis, Wade (1999) analysed professional nurse autonomy. It was found that a student-centred, process-oriented curricular design provided an environment for learning professional nurse autonomy. Wade further posited that the curriculum must emphasise knowledge development, understanding, and clinical decision making.

In a further example of how concept analysis has positively influenced, if not motivated, the profession of nursing to pursue knowledge, Ens (1998) proposed that knowledge of countertransference was useful when dealing therapeutically with the nurse-patient relationship. However, nurses have used the concept ambiguously. Ens

believed that a comprehensive analysis of the concept would assist nurses in recognising it when it occurs and help with understanding the concept and its appropriate use in nursing.

CHAPTER III

THEORY DEVELOPMENT

Bixler and Bixler (1945) stated, "A profession utilises in its practice a well-defined and well-organised body of specialised knowledge which is on the intellectual level of 'higher learning'" (p. 730). Theory development has been metamorphosed into an activity that takes many forms, occurs at a variety of levels of abstraction, and infiltrates each aspect of nursing (Walker & Avant, 1995). According to Chinn and Kramer (1995), theory is defined as "a creative and rigorous structuring of ideas that project a tentative, purposeful, and systematic view of phenomena" (p. 77). Because nursing is practice based, there are practitioners who must educate students, administer educational and service establishments, and develop and test knowledge (Walker & Avant, 1995). Fundamental to the idea of a profession and practice discipline is a commitment to practice based on sound and reliable knowledge. Therefore, theory development "provides a way of identifying and expressing key ideas about the essence of practice" (p. 3).

According to Walker and Avant (1995), there are three basic elements of theory building and three basic approaches for building these elements. The three elements include concepts, statements, and theories. The three approaches include analysis, synthesis, and derivation. This thesis concentrates on both concepts and analysis.

The basic building blocks of theory are concepts. A concept is a mental image of a phenomena; an idea or a construct in the mind about a thing. It is not the thing, but only the image of it (Walker & Avant, 1995). Concepts help us to identify how our experiences are similar or equal by categorising all the things that are alike about them. Indeed, concept formulation is an effective way of learning (Walker & Avant, 1995).

Analysis is useful in areas in which there is an existing body of theoretical literature. The whole is dissected into its component parts, so they can be better

understood (Bloom, 1956). Analysis examines the relationship of each of the parts to each of the other parts and then to the whole. Concept analysis contributes to theory development by providing a way of identifying and expressing key ideas about the essence of practice. It helps nurses to understand practice in a more complete and insightful way. In summary, concept analysis breaks a concept down into its component parts, explores those basic components, then, after having come to an understanding of the total concept, rebuilds the concept.

Method

Walker and Avant (1995) stated that "concept analysis is a strategy that allows us to examine the attributes or characteristics of a concept" (p. 37), but it should never be viewed as a "finished product" (p. 37). Although the analysis itself must be rigorous, the finished product is always tentative at best. The reason for this tentativeness is due to the fact that no two people ascribe the same attributes to the same concept; there always will be some difference, so what is "true" today will probably be "not true" tomorrow (p. 37).

Concept analysis is part of theory building. It encourages communication and, ultimately, understanding among our colleagues about the phenomena being analysed, in this case preceptorship. Ultimately, concept analysis is a careful inspection and description of a word and its uses in the language combined with an explanation of how it is "like" and "not like" other related words (Walker & Avant, 1995, p. 37). Concept analysis results in the clarity of overused yet often misunderstood concepts.

Rodgers (1989), building upon the earlier work of Walker and Avant (1983), stated that the method of analysis includes the following procedures:

1. identifying and naming the concept,
2. identifying surrogate terms and relevant uses of the concept,
3. identifying and selecting an appropriate realm (sample) for data collection,
4. identifying the attributes of the concept,

5. identifying the references, antecedents, and consequences of the concept,
6. identifying concepts that are related to the concept, and
7. identifying a model case of the concept.

To illustrate this procedure, the concept to be identified is *preceptorship*, and related concepts are *clinical teaching*, *mentoring*, *culture*, and *boundaries*. The sample for data collection will be taken from other relevant databases and other disciplines, thus adding further credibility to the study. One important step in concept analysis is constructing a model case (Walker & Avant, 1995). This model case is a "real-life" example of the use of the concept that includes all the critical attributes of the concept. In other words, the model case should stand as a paradigm.

Rodgers (1989) posited that the "identification of references of a concept is to clarify the range of events, situations, or phenomena over which the application of a concept is considered to be appropriate" (p. 334). In terms of identifying antecedents and consequences, further clarity is gained when these are fully explored. Antecedents are the events that are generally found to precede an instance of preceptorship (Rodgers, 1989).

To fully explore the concept of preceptorship, a review of the literature pertaining to a comparison of clinical teaching and preceptorship, paid versus volunteer, knowledge, the role, and evaluation was conducted.

Throughout this thesis, narratives are included to tell a story about preceptorship. The intention is to make the concept analysis of preceptorship alive to the reader.

Northern nursing is an area of nursing where the nurse practices as an advanced practice nurse. The nurse not only carries out the skills typically done in an urban setting but more advanced skills are practised such as suturing, applying splints, well-baby clinics, medivacing someone (transporting someone in a emergency situation by plane, helicopter or boat) to the closest location. In addition to practising more advanced skills, outpost nurses interact with the community, serve on community committees, participate

in community activities, carry out minor maintenance duties at the nursing station or accommodations.

DeDe could not believe it; she was getting Steve, a preceptee from a university out west, as a third-year nursing student. For four weeks DeDe and Steve would be working closely together, with DeDe showing Steve "the ropes" of northern nursing. DeDe had precepted a student once before and thoroughly enjoyed the experience. Because the prior experience had been a positive one, she was looking forward to this preceptorship experience. DeDe had been told only that Steve was an "excellent student" and that he would call soon to see what he needed to bring in terms of food, clothing, and supplies.

Steve had called last evening. DeDe was on call, so the telephone conversation was limited to 15 minutes. DeDe spoke with Steve about the norms, values, and taboos in the village and spoke about what clothing and food to bring. As well, because the village was isolated, Steve was told what local airline service would be needed to get to the community. Steve sounded young and enthusiastic on the phone; his excitement was quite palpable and infectious. In two weeks Steve would be in the community. DeDe now had to get the residence ready for his arrival and start planning the teaching that needed to be done. Steve said he would have his learning goals and objectives ready before he arrived in the community.

The day after the telephone conversation, DeDe phoned Steve's faculty instructor to learn more about Steve. The instructor kept stating how smart Steve was and that Steve had done a major project pertaining to First Nations studies. DeDe was reassured by the instructor and told that whenever she had to phone the instructor for feedback or help, she could do so during business hours. DeDe did wonder about phone contact after hours.

DeDe could remember with fondness her time spent as a post-registered nursing student at a university in western Canada. Her practicum had been very enjoyable, and

to this day DeDe considered her preceptor her mentor. DeDe was considered by her peers as an expert in northern nursing and took pride in keeping up to date with the latest research in that area. Even though DeDe had not been formally educated as a preceptor, she still felt capable of teaching a student. DeDe knew about the principles of adult education, communication theory, and constructive feedback, but what was to transpire over the next four weeks had not been contemplated.

Review of the Nursing Literature

Comparison of Clinical Teaching and Preceptorship

There is a plethora of literature addressing preceptorship. Prior to understanding preceptorship, one must understand the relationship between clinical teaching and preceptorship. Explicit in any teaching and learning connection is the "relationship" between the teacher and the student. This professional relationship involves a power imbalance, usually defined in terms of "role"; for example, the teacher and the student are viewed in terms of advantage (teacher) and disadvantage (student) (Clark, 1998). A power-disadvantaged relationship does not necessarily indicate an abusive or exploitive relationship; most disadvantaged relationships involving a student and teacher result in benevolence (Clark, 1998). Whereas the clinical teaching role involves a top-down power dyad, with the student being viewed as a neophyte and the teacher viewed as the expert, the preceptorship role involves a relationship of potential collegiality, in which the preceptor and preceptee are viewed more as equals. When the preceptorship relationship occurs in a rural, isolated environment, the relationship can develop even stronger ties. The fact that there can be thousands of miles separating the preceptee and preceptor from the faculty member as in the case of DeDe and Steve can lead to an even more benevolent relationship or even go to the extreme opposite. The preparation for the role of preceptor and preceptee is therefore very important. In terms of the narrative story, the

reader could ask whether DeDe and Steve had proper preparation for their respective roles.

The literature describing the preparation for the role of a preceptor dealt mainly with the clinical realm. There were no articles that dealt with the proper preparation of a preceptor. With regard to the preparation of clinical teachers, the instructors have a security system and easily accessible resources right at their fingertips, whereas preceptors usually do not have that luxury. To obtain support, preceptors usually have to rely upon communication through the telephone, fax machine, email, or visitation.

Preparation for the roles of clinical teacher and preceptor can vary greatly. According to Letizia and Jennrich (1998), "Staff nurse preceptors may have little or no preparation for the clinical teaching and the activities involved with student evaluation" (p. 213). Atkins and Williams (1995) and Ferguson and Calder (1993) also found that there was little preparation for preceptors. To rectify this problem, formal and informal instruction regarding teaching methods, techniques, and the evaluation process should be provided to the preceptor. The preceptor is typically selected based upon strong clinical and leadership skills, superior communication skills, concise decision-making ability, and interest in personal growth. Myrick and Barrett (1994) posited that other critical qualities included having a strong knowledge base, organisational ability, concern for the preceptee, effective teaching skills, and role commitment. However, reality suggests that preceptors are chosen based on who is available (Letizia & Jennrich, 1998) as in the case of DeDe.

Ferguson (1996) suggested that even though preceptoring is a demanding role for the practising nurse, the preceptor may not be educationally prepared to teach students. This notion was strongly supported in literature. To illustrate, Wong and Wong (1987) postulated that nurse educators are under increasing pressure to engage in research. Indeed, nurse educators employed by faculties of nursing are pressured to "publish or perish," forcing these educators to focus more upon their research and allow the teaching

of the student to rest primarily with either the inexperienced or the part-time sessional instructor. Karuhije (1987) noted that few clinical teachers, let alone preceptors, are adequately prepared for the role. Hart and Rotem (1994) supported this theory. Furthermore, it is interesting to note that as late as 1962, nursing school administrators assumed that if a new teacher possessed an academic degree, he/she could teach (Clissold, 1962). Today, this is not necessarily the case.

Harding (1998) stated that "the importance of good teaching in the clinical field is that it offers a vital contribution to the maintenance and constant evaluation of standards for patient care" (p. 41). Therefore, whereas clinical teaching conveys the universals, norms, and rules basic to the practice of nursing, preceptorship builds an appreciation in the neophyte for the subtleties and varieties that occur in the real world (Barnum, 1997). There are many debates amongst nursing scholars, both clinically and research based, about the roles of the clinical teacher and the preceptor. Specifically, the question that needs to be asked is, "Is clinical teaching equal to or not equal to preceptorship?" There are few, if any, research articles addressing this very salient question.

The two weeks prior to Steve's arrival in the community had been busy for DeDe. DeDe not only had to inform the Band Council of Steve's imminent arrival, but she was busy planning what she believed Steve needed to learn regarding northern nursing. DeDe believed in role modelling the neophyte; actually, she believed that it was her professional and personal duty to pass on knowledge to the student. Some areas she would teach included: complete histories and physical exams, well-baby exams, well-elder exams, immunization schedules including an immunization exam, suturing techniques, splinting a limb, electrocardiogram (ECG) monitoring, home visits, public relations and trauma care such as intubation, starting intravenous lines, and familiarizing Steve with the emergency drug cart.

The day Steve arrived in the village was exciting for DeDe because she could now begin to model what northern nursing was all about. Steve introduced himself to DeDe,

who then took Steve to his accommodation. He was given two hours to settle and then was instructed to come to the nursing station for introductions.

After one week, DeDe sensed something was not right. Steve appeared to be having trouble with boundaries (accepting gifts and dressing inappropriately) and following the Code of Ethics for nurses. DeDe emailed her concerns to the faculty instructor. DeDe received an email in return stating that the faculty had had misgivings about sending Steve to the community. DeDe wondered why she had not been informed of these misgiving. DeDe spoke with Steve in private about her concerns and formulated a plan to address the concerns. Steve was to do a literature search on the Web about the principles of adult education, boundaries, and the Code of Ethics. Within one week Steve and DeDe met again to discuss the results of his Web search. During the second meeting DeDe reassured Steve that his clinical skills were acceptable, but she was concerned about Steve's understanding of those concepts. Steve stated that he understood DeDe's concerns and that he would work on them. Unfortunately, the last two weeks of the practicum demonstrated to DeDe that Steve did not understand the concepts. For example, the behaviors the Steve demonstrated during the final weeks of the practicum were of great concern, and included the following:

1. *failing to inform DeDe of a suicide attempt of a teenager,*
2. *accepting a gold necklace from an elder from the village,*
3. *smoking Marijuana with two men while at the lake, and*
4. *failure to report a rape that occurred at a party he had attended.*

In retrospect, DeDe believed that she was not adequately prepared for this preceptorship experience. Because she had never dealt with an culturally and ethically unsafe student before, she did not know what recourse she should have taken to deal with the matter effectively. As well, she was not well supported by the faculty instructor, who was difficult to reach during business hours and did not give DeDe emotional support. Thank goodness there was a second nurse in the community who gave support to DeDe;

otherwise she might have gone mad with frustration and a sense of powerlessness. DeDe needed to be educated by the faculty instructor regarding giving constructive feedback, evaluating students, preceptorship, and failing an unsafe student. When Steve left the community he gave DeDe a jacket with the logo of the university he attended. He told DeDe that his faculty instructor told him to bring something to give to the preceptor.

Paid Versus Volunteer

Dodds (1979) stated that the major work of the clinical teacher is teaching the student the basics about nursing knowledge. This same assumption can be stated today; nothing has changed. Whereas the clinical teacher is paid for their work, the preceptor, like DeDe, usually volunteers for the role. The preceptor is also a staff nurse with the responsibility of a patient load. Because preceptors are not paid for their role, other methods of appreciation must be addressed. The literature stated many avenues by which to reward the preceptor. Yonge, Krahn, Trojan, and Wilson (1995) stated that a reward must be reflective of the preceptor's educational and professional role.

Rewards can be external and internal. For example, external rewards include peer recognition through a social reception or a luncheon, feature stories in institutional newspapers, money, promotions, and honorary titles (Corrigan, 1992; Hitchings, 1989; Lewis, 1990; Limon, Bargagliotti, & Spencer, 1982; Shah & Polifroni, 1992; Turnbull, 1983). Intrinsic rewards include a donation of a library book in the preceptor's honour, a certificate of appreciation, a subscription to a journal, a letter of appreciation from a nursing supervisor or director of nursing, continuing education tuition, and designation as a clinical affiliate faculty member from the nursing program (Cawley, Bopp, Kruckenberg Schofer, Langenberg, & Matheis-Kraft, 1994). Intrinsic rewards can be more personal in nature. For example, Dilbert and Goldenberg (1995) posited that benefits can also include the opportunity to teach, to influence practice, and to increase

one's own knowledge base and stimulate thinking, as well as to observe the preceptee grow (Stevenson, Doorley, Moddeman, & Benson-Landau, 1995).

When Steve left the community he gave DeDe a gift of a jacket. While that was a thoughtful gesture, DeDe wondered if the giving of the gift was in some way a bribe by Steve to sway DeDe into giving him a passing grade for the practicum. DeDe discussed this with the faculty instructor and was told by the faculty member that the gesture would be noted in Steve's final evaluation.

Knowledge

The bottom line for both the clinical teacher and the preceptor is to convey knowledge to a student. Teaching strategies employed to reach this goal can be traditional; for example, a lecture format or through some creative means such as stories, games, panel discussions, group discussions, case studies, hands-on experience, and clinical labs. The clinical teachers can employ more varied teaching strategies, because they usually have access to more resources such as CD-ROMs and libraries; they also have more time. In comparison the preceptor, because of lack of time for research and resources, relies more predominantly on stories, available textbooks, and journal articles.

Regarding clinical teaching, the student initially depends on the teacher; then, later in their nursing program, the student moves to a one-on-one relationship with the preceptor. However, regarding preceptorship, the relationship is immediately one-on-one (Ferguson, 1996; O'Shea, 1994), and the relationship is usually sustained over time. The teacher-student ratio for clinical teaching is usually 1:8, 1:10, 1:12, or even greater, with the relationship usually not sustainable over time (Cawley et al., 1994; Fitzgerald, Wadman, Jacobs, & Anderson, 1999; Letizia & Jennrich, 1998; Melander & Roberts, 1994).

DeClute and Ladyshewsky (1993) suggested that a 1:2 ratio is a valid clinical education model. Their empirical study determined that those students in collaborative

learning placements (two students to one clinical instructor) differed on measures of clinical competence compared with students in traditional clinical placements (1:1). Areas that were enhanced by utilizing a collaborative learning model included patient education, program planning, implementation of treatments, communication, management skills, professional behaviour, and documentation.

Taylor (1941) stated, "It is also at the bedside that the true spirit of nursing is passed from the great teacher to the student. No other kind of teaching and learning will take its place" (p. 505). Stewart (1943) and Wong and Wong (1987) supported this statement. >From as early as the Second World War, nurses have acknowledged that the basic knowledge learned at the bedside is important as the foundation of nursing knowledge. Students learn basic nursing skills, as well as professional values, and are socialised into the professional role of the nurse (Fitzgerald et al., 1999; Letizia & Jennrich, 1998; Wiseman, 1994; Wong & Wong, 1987). Likewise, preceptorship fosters role inculcation (Barnum, 1997; Ferguson, 1996; Yonge, Krahn, Trojan, & Reid, 1997) by modelling the behaviours, attitudes, values, beliefs, and professional role of the preceptor.

Steve, felt very fortunate to have a preceptor as skilled and knowledgeable as DeDe. While in the community Steve learned some very valuable skills such as starting an intravenous line, history taking and physical examination, drawing blood, applying a splint. As well, Steve learned the role of the administrator. For example, ordering pharmacy and office supplies, ordering maintenance work for the nursing station, and doing the month end report.

The Role

The clinical teacher must wear many different hats throughout his/her clinical teaching experience. For example, the teacher may at times be a student counsellor, an evaluator, a liaison between the faculty and the organisation, and an occasional ward nurse during busy periods (Wong & Wong, 1987). The clinical teacher is not a colleague to the student but acts exclusively as an educator and therefore models teacher behaviour (Wong & Wong, 1987). Conversely, the role of the preceptor is broader and possibly less narrowly defined. The preceptor's role is usually one that the clinical teacher assumes in addition to that of mentor, educator, evaluator, colleague, or role model, (Fagner, 1998; O'Shea, 1994) and, perhaps over time, a friend.

Evaluation

To show that students have gained nursing knowledge, both the clinical teacher and the preceptor must conduct student evaluations. This is usually viewed as a necessary evil (O'Shea, 1994). Evaluation of a student is done informally and formally. In an exploratory descriptive survey of 295 nursing preceptors, Yonge et al. (1997) stated that, generally, the informal ongoing evaluative process is not difficult, but the formal process can be fraught with difficulty. Specifically, neophyte preceptors who do not have experience with this process could experience problems with evaluation. Yonge et al. found that 98.3 % of the 295 nursing preceptors had evaluated nursing students. Of the 295 preceptors, 276 (92.6%) stated that they should have been involved in the evaluation process, whereas only 15 (5.1%) stated that they should not have been involved in the process. Of interest, only 28.8% stated that they had been shown how to do student evaluation.

Yonge et al. (1997) noted that an evaluative task looked upon with dread is assigning a failing grade to a student. Specifically, 16 preceptors (5.4%) had failed a difficult or weak student, one had attempted to fail a student but had been overruled, and

the remaining 93.2% of preceptors had not failed a student. Some preceptors felt that their evaluative part in the teaching process was difficult due to unacceptable evaluation forms, difficulty with objectivity, time pressures, weakness of the student, and the need for additional data. However, the majority of preceptors gave cogent reasons in support of their participation in the evaluative process: their one-on-one relationship with the student, observing the student in the field, and following the principles of teaching and learning theory.

Gomez, Lobodzinski, and Hartwell West (1998) discussed three questions confronted by faculty when evaluating a student: Who will perform the clinical evaluation? When will the evaluation be conducted? How will the information be used? Regarding the first question as to who would perform the evaluations, faculty, self, peers, patients, and nursing staff are all likely candidates, with advantages and disadvantages associated with each. With regard to when the evaluation is to be conducted, the value of formative and summative evaluation is important. Giving a final evaluation can be harmful to the student, especially if the result is unexpected. The final question addresses who will have access to the data. All persons involved should be aware at the outset of the purpose and the impact of the evaluation on all of the involved individuals.

Gomez et al. (1998) discussed five methods of clinical evaluation: (a) observation, (b) written communication, (c) oral communication, (d) simulation, and (e) self-evaluation. Because of the complex nature of clinical evaluations, more than one method may be appropriate. As well, these authors discussed five evaluation instruments: rating scales, checklist, anecdotal records, critical incidents, and videotape. Next, Gomez et al. discussed four evaluation instruments for written communication methods, including charting and nursing notes, nursing care plans, paper and pencil tests, and process recordings. They also addressed two instruments for oral communication methods: clinical conference or postconference and multidisciplinary conferences. As well, simulation exercises can be utilised as evaluation instruments in clinical practice,

such as the Objective Structured Clinical Examinations (OSCE), role-play, and interactive multimedia, along with self-evaluation through journals/logs and personal interviews.

Letizia and Jennrich (1998) posited that to adequately prepare the nurse-preceptors for their role, they must be provided with formal and informal instruction regarding teaching techniques, methods, and the evaluation process. DeDe believed that she was not prepared in the area of evaluation. This was particularly stressful to her given Steve's behaviors in the community. Another issue pertains to how much the preceptor participates in the student's evaluation. O'Shea (1994) noted that to evaluate a student's performance objectively, a combination of formative and summative evaluation techniques should be used. Formative evaluation is often verbal, whereas summative evaluation is written and based on performance data; the summative evaluation should contain no surprises for the student and contains both strengths and weaknesses.

With regard to evaluation by the clinical teachers, they have more normative data with which to compare students. Given that in the clinical setting the teacher-student ratio is anywhere from 1:8 to 1:12, it is easier to get a better idea of how well each student is progressing (formative evaluation). The opposite could be said for the preceptor. To illustrate, the preceptor/preceptee ratio tends to be 1:1 which means that the preceptor cannot evaluate the student with normative data. For example, due to the limited amount of normative data that DeDe possessed, she was careful not to inadvertently label Steve as "good," "bad," "very intelligent," or "severely lacking." Another important point for clinical teachers is that they usually have background information on their students. In the case of DeDe, she did not receive adequate information, and only when she pressed the faculty member did she receive more information.

The time to complete Steve's evaluation had arrived. DeDe did not know what to do. Steve was clinically competent for a third year nursing student, but he was incompetent both culturally and ethically. DeDe decided to pass him clinically but to fail

him in the other two areas. In the narrative section of the evaluation, DeDe provided a detailed explanation for her decisions.

Summary

The concepts, values, norms, and knowledge explicit and implicit to the areas of clinical teaching and preceptorship are vast. It is no wonder that nursing scholars engage in heated debates about these two domains. As the profession of nursing develops and expands its borders, these two fundamental areas of nursing are bound to undergo further change, research, and discussion. That notion is exciting. After having explored preceptorship in terms of clinical teaching, paid versus volunteer, knowledge, the role of the preceptor, and evaluation, preceptorship programs must then be examined.

Preceptorship Programs

For a preceptorship experience to be successful, the educational program preceptors implement must be appropriate and scholarly, teaching appropriate clinical skills. Faculty who understand preceptorship and support the preceptor and the preceptee should facilitate the preceptorship program. DeSimone (1999) described an internship designed and implemented by baccalaureate and associate degree faculty and nurse administrators at a local community college. DeSimone proposed that for new nurses to be adequately prepared for clinical competence and leadership, programs must be available that enhance these competencies. This co-operative program was designed to assist new nurses in their development as nurse leaders. Eight mentors and seven interns completed the program. The interns stated that they valued learning on site from the mentors and preceptors, explaining that the process increased their feeling of collegiality with staff nurses and supplied support for graduates lacking confidence.

Ryan and Brewer (1997) described a mentorship program combined with a professional role development course that was integrated into a BSN nursing program. The program was designed as a professional seminar and formatted "to begin the

successful transition of the entry-level nursing student into the role of professional nurse" (p. 21). Faculty mentors were chosen to serve as academic advisors, role models, and advocates for individual students for two years. An evaluation of the mentorship program commenced at the end of the first semester in conjunction with the evaluation of the professional role development seminar (Ryan & Brewer, 1997). The data from the initial survey were positive. Out of 90 students, 81 completed the survey. In addition to the initial survey, at the end of the spring semester students were asked to participate in focus groups to obtain more qualitative data. As the student progressed in the program, evaluation continued.

According to Modic and Bowman (1989), developing a preceptor program is not an easy task. The authors described one preceptor program, from Cleveland, Ohio, thought to be successful in nursing staff development. Staff nurses were prepared for the preceptor role via a two-day workshop, followed by a four-hour teaching practicum. The course endorsed educational skill development and affective awareness. The program described the preceptor program, role responsibility, and adult learning principles (Modic & Bowman, 1989) and addressed the socialisation process which orientees encounter. A tool developed by Kolb (1984) was utilised to determine the learning styles of the orientees. As the preceptor program expanded, it became necessary to identify the roles of all parties involved. The delineated role responsibilities included those for the head nurse, assistant head nurse, clinical instructor, nursing education instructor, preceptor, and orientee.

Cantwell, Kahn, Lacey, and McLaughlin (1989) described a survey of hospital preceptorship programs in the greater Philadelphia area. The survey gathered data "on the number of preceptorship programs, the reason for their initiation and continuance, and similarities and differences in structure, process, content, and outcomes" (p. 225). A 25-item questionnaire comprised of both closed and open-ended questions was mailed to 60 acute care hospitals, with 35 hospitals responding. The data analysis revealed that the

number of preceptor programs had risen since 1980. The process, structure, and content of these 35 programs were similar. The data also revealed that the majority of preceptorship programs lacked a formal evaluation process or a cost analysis of program benefits. The questionnaire asked questions about the selection and training of preceptors and program effectiveness. Over half of the respondents rated communication, decision-making ability, and clinical skills as being extremely important in the selection of preceptors. Although 35 hospitals stated that they had a preceptorship program, only 28 indicated that they had a well-defined description for the role of the preceptor. The preceptorship program lasted one to three months. It is important for nurse educators to plan for an evaluation of preceptorship programs prior to the commencement of the program to quantify the effectiveness of the program.

Although preceptorship programs largely benefit the health care facility, the preceptor, the preceptee, and the nursing profession, there are noted drawbacks. Lewis (1990) identified several problems with preceptorship programs and offered solutions to these problems. Preceptor stress/fatigue is a major problem. The full-time nurse chosen as a preceptor is repeatedly assigned a preceptee in a clinical area in which there are a limited number of staff. Another problem related to stress addresses the personality of the preceptor. Not all people get along, and some preceptees' demeanour or personality irritates the preceptor and vice versa.

Another concern relates to stress of the different educational preparation of the preceptor and the student; for example, if a diploma-prepared nurse is paired with a baccalaureate student. Also, evaluation of the student leads to nurse stress. Nurses have not been educated about how to formally evaluate another's care. The student who is a poor performer and requires much direction contributes to nurse-stress. The heavy workload of the nurse-preceptor contributes to his/her stress. Not only do they have to care for their clients, but they also have to monitor the student. As well, compensation is an issue. There is no reward or acknowledgement for the preceptor. Another area of

concern relates to the discrepancy between the goals of the health care facility and the nursing institution. Division of labour in preceptor planning is an issue.

Recommendations to resolve the above problems include the following (Lewis, 1990):

1. Provide extra preceptors for each unit. These trained individuals would then allow for rotating rest breaks.
2. Preceptors should be asked to engage in the preceptorship. Those who refuse should be supported for their decision.
3. The personalities of the preceptor and preceptee should be discussed beforehand. Both preceptor and preceptee should be able to meet with the faculty member to communicate learning styles, personality types, or conflicts.
4. Preceptee problems should be identified early in the program and should be discussed with the preceptee and preceptor.
5. Preceptors should be allowed to provide (objective) formal feedback regarding the student's progress. It is not the job of the preceptor to pass or fail the student.
6. Reward systems should be devised for preceptors between the service and educational institutions. Health care administrators should be made aware of the contributions of nurse-preceptors and should support them in the role.
7. Co-organisers of a preceptorship program should include one hospital administrator and one hospital-based nurse educator/faculty member to ensure a better-balanced program.
8. At the beginning of any preceptorship program, the co-organisers and other key stakeholders must meet to discuss common goals and set rules and regulations to be followed in case the preceptor is absent.

Miller and Brosovich (1991) presented their observations of factors that "have contributed to the success of a program in intensive care units (ICUs) after the initial pilot" (p. 81). Nurse retention and recruitment are key factors contributing to the success of the ICU program. Preceptors have provided the ICU with a cost-effective means of orienting new nurses. Collaboration between preceptors, preceptees, and leadership strengthen the preceptor program. Orientation of new nurses occurs over an eight-week process. Another factor contributing to the program's success is preceptor lunches that are held twice a year. The luncheon is scheduled for two hours and is held on two different days during a predetermined week. Formal and informal evaluation of the program is ongoing. At the end of the orientation program, formal evaluative tools are utilised by the instructor and completed by the preceptee and preceptor. The results of the evaluations are shared formally at a meeting.

Bartz and Srsic-Stoehr (1994) conducted a survey of 70 Army Nurse Corps (ANC) officers on preceptorship program content and process. The sample provided information about "personal, interpersonal, clinical, and environmental characteristics of preceptorships" (p. 153). The preceptor characteristic rated most important by the sample was clinical competence, and a positive attitude placed second. Other important preceptor characteristics include being an effective teacher and communicator, role modelling, honesty, having clinical experience, being a leader, and having a military/professional bearing. The least important characteristic was experience as a preceptee. Bartz and Srsic-Stoehr noted that head nurses should select preceptors, and the program should be between four to six and seven to nine weeks in length.

According to Davis and Barham (1989), nursing faculty and agency staff "can maximise resources by collaborating on program design from the ground up" (p. 167). A number of issues that affect collaboration in the design, implementation, and evaluation of preceptorship programs are discussed. Areas for discussion include administration issues, including setting selection, preceptor selection, roles and responsibilities, legal

considerations, and communication; student and preceptor issues, including learning objectives and preceptor support; and evaluation issues.

Nordgren, Richardson, and Laurella (1998) discussed a collaborative preceptor model for clinical teaching of beginning nursing students. Apparently, in North America four clinical models are utilised to teach beginning degree student nurses. These models include the traditional model, the preceptor model, the clinical teaching associate model, and the modified clinical teaching associate model. Faculty at the University of Utah responsible for neophyte student nurses compared the four models and discussed the advantages and disadvantages noted in the literature.

Areas discussed with all four models included level of the student, RN-to-student ratio, faculty-to-student ratio, faculty presence, faculty services offered, faculty appointment for staff, evaluation of student, advantages, and disadvantages. Regarding the preceptor model, the level of student is advanced, the student-to-nurse ratio is 1:1, the faculty-to-student ratio is 1:14-18, faculty presence is not required nor is it offered, there are faculty appointments for staff, and the faculty and RN evaluate the student. Advantages include better utilization of instructor time, increased student confidence and skill acquisition, and provision of a more realistic clinical preparation. Disadvantages include the late occurrence of the nursing education program, the lack of integration of theory and research (this contributes to the theory-practice gap), and less flexible student placements. The data from this pilot study clearly demonstrated that student nurses benefited from the preceptored clinical experience by receiving individual attention, experiencing multiple learning opportunities, developing independence, and strengthening their self-confidence.

Summary

It appears from the reviewed literature pertaining to preceptorship programs that the following areas are highly important to the successful completion and implementation of the programs. The areas include, but are not limited to, selection criteria for the preceptor and preceptee, evaluation of the preceptee, rewarding the preceptor, and issues of stress for the preceptor. As well, identification of the learning styles of the student and appropriate communication and collaboration among the health care facility, faculty, preceptor, and student nurse are important.

An area related to preceptorship is mentorship. This concept must be explored to decrease confusion and differentiate between the two concepts.

Mentorship

Mentoring is acknowledged as a relationship between an experienced nurse (the mentor) and a neophyte, or less experienced, nurse (the mentee) (Atkins & Williams, 1995). There has been a great deal of dialogue in the nursing literature about mentorship or mentoring. In particular, nurses have debated mentor preparation and support and the apparent lack of understanding about the role and meaning of the concept of mentoring (Andrews & Wallis, 1999; Armitage & Burnard, 1991; Atkins & Williams, 1995; Duffy et al., 2000; Neary, 2000; Watson, 1999; Wilson-Barnett et al., 1995).

An article by Scotsmen Duffy et al. (2000) reported on the 1999 results of a survey that investigated the effectiveness of current arrangements for mentor preparation and continuing mentor support, with a response rate of 71 out of 150 mentors. A problematic area identified pertained to adequate support from both managers and academic staff. Implications for practice include that mentors require support for their role in supporting students on preregistration adult programs, mentors require support from managers to attend mentor preparation study days, lecturers need to be seen in

placement areas, and communication needs to be clear between the placement areas and the universities.

What does mentor mean? Armitage and Burnard (1991) pondered that question. They proposed that, if there is no agreement upon a definition of a concept, then one cannot assume that everyone is talking about the same thing when referring to mentorship. Armitage and Burnard suggested that the mentor would look after and guide the novice nurse. An objection to this is that being looked after does not follow the principles of adult education (Knowles, 1984). The authors stated that the main difference between mentorship and preceptorship is that the preceptor is more clinically active and acts as a role model, whereas the mentor seeks a closer, more personal relationship with the novice. Armitage and Burnard reported that in 1974 Kramer introduced the concept of nurse-preceptor in an attempt to bridge the theory-practice gap. Decreasing the differences between what was taught in the classroom and what occurs in real life would allow nursing students to become better prepared for the working world.

Morales-Mann and Higuchi (1995) discussed an article describing the phases of a transcultural mentoring relationship between Chinese nurses and Canadian nursing professors. To guide the experience, they utilised Mezirow's adult learning theory of perspective transformation. The article provided a description of the mentoring process using Mezirow's framework, described how this process differed from the traditional mentorship model, identified factors that influenced the mentoring relationship, and explored what was learned from the mentoring process to make recommendations based on the authors' experiences. Influencing factors that affected the mentoring relationship included culture, knowledge, attitudes, skills, and past experiences of the mentee. An important lesson learned pertained to preparation for the mentorship relationship. For example, orientation to the program is important for both the mentor and mentee, keeping in mind the culture and characteristics of the people of China and Canada. Each mentor and mentee needs to receive background information on the other. As well, a list of the

mentee's preliminary objectives needs to be sent to the mentor so that appropriate planning can occur. The role, functions, and responsibilities of the mentee and mentor must be made explicit.

Woodrow (1994) explored implications, obstacles, and benefits created through mentorship. Mentors have been defined as experienced and trusted advisors as well as wise counsellors selected by students to assist, guide, and befriend (Woodrow, 1994). Woodrow posited that, normally, mentors are not involved with formal supervision or assessment of the student. Rather, mentors (teachers) become facilitators for learning, whereas the learner takes responsibility for his/her own learning (Knowles, 1984). Woodrow stated that teaching becomes "not just imparting knowledge, but identifying resources, enabling learners to gain relevant experience, and offering formative feedback" (p. 813). Mentorship helps to reduce the theory-practice gap by encouraging the mentee student to learn from experienced nurses practising in the clinical field.

The mentor is also accountable under the code of conduct and must therefore possess appropriate qualifications to assess and be clinically competent and credible (Woodrow, 1994). A wrong assumption made in nursing is that many nurses have developed mentorship skills. This is not necessarily so. Mentorship study days must be offered to mentors to develop mentoring skills. Mentors unable to identify or analyse their own skills are poorly placed to identify or analyse skills of others (Woodrow, 1994). Because of the close working relationship between the mentor and the student, problems and conflict can occur. For example, as the mentee grows professionally, his/her views may conflict with those of the mentor. Transference may occur as a direct result of mentoring. If the role model (mentor) lacks interpersonal and conflict resolution skills, both, or perhaps one person, may become emotionally hurt (Woodrow, 1994). Many questions remain regarding mentorship, such as, "How does mentorship differ from other concepts such as preceptorship? Does this semantic difference make any practical difference? How will such support systems be implemented? What are the consequences

of implementation? And how will detrimental consequences be overcome or minimised?" (Woodrow, 1994).

In a qualitative research study, Atkins and Williams (1995) explored and analysed registered nurses' experiences of mentoring undergraduate nursing students in England. Twelve mentors consented to participate in semistructured interviews. Six conceptual categories were identified as supporting the student, facilitating learning, learning through students, managing conflicting roles and responsibilities, the mentor being supported by colleagues, and working in partnership (Atkins & Williams, 1995). Key activities deemed important by mentors were facilitating mentee learning and supporting them. Key issues identified pertain to the following: Mentors require formal academic preparation for their role and should be familiar with the principles of adult learning (Knowles, 1984), facilitation, and reflective practice. Another key issue pertains to role modelling by the mentor. The area of conflict needs to be further addressed. Commitment, time, and energy spent by the mentor are significant, and mentoring responsibilities must therefore be addressed by nursing establishments. Support of the mentor by his/her colleagues is highly significant for the mentorship relationship to thrive. Mentors must feel supported and appreciated by their peers. In addition, mentoring activities need to be more widely recognised and accepted by colleagues as integral to the nursing profession.

According to Watson (1999), the meaning of mentoring has been distorted. Andrews and Wallis (1999) and Wilson-Barnett et al. (1995) supported this. Watson described an English qualitative study investigating the mentoring experiences and perceptions of preregistration nursing students in one organisation. Fifty people consented to participate in the study, which was comprised of 35 students in a Common Foundation Programme, and 15 mentors. The implications of this distortion were discussed.

According to Watson (1999), there was little agreement on the meaning of the concept of mentoring; however, he believed that a mentor should be chosen by the student to assist, guide, advise, and counsel, and should not be involved in the formal supervision or assessment of the student. This relationship is not one-sided. Rather, the mentee has to be prepared to be open and willing to learn (Watson, 1999). The mentor personally invests in the professional growth of the mentee. Watson noted that Oliver and Enderby (1994) believed that the terms *mentoring* and *preceptorship* have been utilised interchangeably within nursing practice. Watson stated that the concept of mentor has its origins in Greek mythology.

The results of the study determined four categories pertinent to both the student and the staff, which included the need to understand the mentor role, an introduction and preparation for their roles, experiences of mentoring in the clinical area, and perceptions and views about mentoring. This study confirmed that the "mentoring role is defined according to individual understanding, and is not necessarily based on any of the original concepts of the term" (Watson, 1999, p. 260). Atkins and Williams (1995) shared the belief that preparation for the mentoring role is vital. Guidelines should be determined in areas such as mentor preparation, the actual role and responsibilities, appropriate staff qualification, and educational and institutional support that mentors require.

Andrews and Wallis (1999) reviewed the mainly British literature associated with the supervision of student nurses, which focused more on the nature and practices of mentorship in practice settings. Their literature review revealed that there is a great deal of discord regarding both the concept of mentorship and the mentor's role. The authors also noted that there is inconsistency in the level and length of mentorship courses.

The term mentorship began to appear in the nursing literature in the early 1980s, which resulted in an abundance of published articles in the 1990s (Andrews & Wallis, 1999). Until the mid-1980s, an apprenticeship style of clinical learning was utilised in the clinical setting. However, in the late 1980s informal mentorship programs became

essential to preregistration education. Andrews and Wallis stated that the origins of the concept of mentorship are Homer's *Odyssey*. Mentor, a wise and dependable friend of Odysseus, took care of Odysseus's son in his absence. The concept of mentor assumes the connotations of a wise older man who takes on the tutelage of a younger man.

Andrews and Wallis (1999) noted that nursing needs a consistent definition of the concept of mentor. Neary (2000) and Wilson-Barnett et al. (1995) agreed with this statement. As well, Wilson-Barnett et al. posited that the terms *mentor*, *assessor*, and *supervisor* are used interchangeably to represent the same role. This literature review outlines the differences between preceptorship and mentorship, with preceptorship being a more short-term relationship than mentoring and with preceptors being responsible for teaching and evaluating the students' clinical performance.

Effective mentoring incorporates significant personal characteristics such as approachability, effective interpersonal skills, good teaching skills, support, and professional development ability. Andrews (1993), Earnshaw (1995), and Rogers and Lawton (1995) supported this. Identified as key mentoring roles are inspirer, inventor, and supporter. Darling (1984) endorsed this identification. Andrews and Wallis (1999) also pondered who should act as mentors and what constitutes adequate preparation for undertaking the role.

In a qualitative study, Wilson-Barnett et al. (1995) reported on research commissioned by the English National Board for Nursing, Midwifery, and Health Visiting on mentorship and clinical support arrangements for Project 2000 nursing students. The authors suggested that the concepts of mentorship, assessor, and supervisor were utilised interchangeably in both the clinical and community settings. Despite the fact that the extent of dissatisfaction with planning and preparation for Project 2000 students was widespread, there were positive examples by the students that provided insight into the factors that can facilitate appropriate and effective student learning. The examples include appropriate supernumerary status, staff commitment to teaching,

students working closely with practitioners, linking tutors in regular contact with clinical areas, well-planned student learning experiences, practitioners with adequate time for students, supportive staff, and a good team spirit (Wilson-Barnett et al, 1995). Academic preparation for the mentorship role is highly important and must be provided to the mentors.

Neary (2000) reported on two longitudinal studies. The first study occurred between 1991 and 1995 and examined the experiences and perceptions of 155 nurses and 300 students from three colleges of nursing and 45 interested nurses. The second study occurred between 1992 and 1994 and looked at the process and outcomes of practitioner-teachers and mentorship in Wales. It was based on the data from an extended period of semistructured interviews with managers, policy makers, teachers, and nurse practitioners. The full study concluded with the suggestion that policy makers, teachers, and practitioners must find ways to make identifiable improvements to the methods for defining who becomes a mentor and an assessor, for creating standards of teaching nursing practice, and for assessing the outcomes which are intended to develop students' competence as a critical reflective practitioner, ensuring their ability to practice nursing. Neary contemplated the need to concern themselves with how to teach, assess, and support students effectively rather than with what to call themselves.

Summary

The nursing literature was unclear about the definition of mentor or mentorship. The articles reviewed for this thesis are a case in point. Although most of the articles described the roles and/or attributes inherent in mentorship and mentoring (Armitage & Burnard, 1991; Atkins & Williams, 1995; Duffy et al., 2000; Morales-Mann & Higuchi, 1995; Neary, 2000; Wilson-Barnett et al., 1995), three articles explicitly defined the concepts (Andrews & Wallis, 1999; Watson, 1999; Woodrow, 1994). Armitage and Burnard stated that "if mentoring is to become a significant part of the education and

training of nurses, then it would seem reasonable to call for some clarification of the concept" (p. 226). Interestingly, Armitage and Burnard did not define the concept in question. Watson stated that if the term mentor is not being clearly defined, then it could not be applied appropriately.

Another theme evident in the literature pertains to how the theory-practice gap relates to and is interwoven with mentorship (Andrews & Wallis, 1999; Armitage & Burnard, 1991; Neary, 2000; Wilson-Barnett et al., 1995; Woodrow, 1994). A question arose regarding the article by Duffy et al. (2000). Specifically, did the authors mean to utilise the concept of mentor, or did they need to use the concept of preceptor? It appears that the use of the concept preceptorship would have been more appropriate.

Equally relevant in terms of the preceptorship experience is the legal and ethical issue of the teaching and learning relationship.

Boundary

Halstead (1998) provided an overview of the legal and ethical issues related to the academic performance of students. Topics discussed included academic failure in the clinical and classroom settings, methods of assisting students through this difficult experience to ensure due process, and the importance of communication of student and faculty expectations. Students bring to the classroom richness and diversity of life experiences because they possess a wide array of knowledge, skills, values, beliefs, and needs that will help form the profession of nursing. Nurse educators find it challenging to meet the needs of these varied students through the "establishment of relationships that are positive and empowering in nature" (p. 55). Whereas most students are clinically and academically successful, others may experience difficulty in balancing the multiple roles and responsibilities of their lives. Nevertheless, faculty are responsible to provide support and guidance to all students in the courses.

Nursing is a practice-based profession in which direct patient care obviously occurs. As a result of the care, professional and personal boundary concerns can ensue. The Alberta Association of Registered Nurses (AARN, 1996) composed guidelines for ethical decision making. This is one tool that nurses utilise to practice ethically and professionally. The Nursing Profession Act of 1983 legislates self-governance for Alberta nurses. The mission statement of the AARN (1996) is to "secure the provision of safe, competent, ethical nursing care to all Albertans" (p. i).

The AARN (1998) discussed professional boundaries within the nurse-client relationship. Outlined in the document are expectations for professional behaviour of registered nurses in the nurse-client relationship, what to do when boundaries are crossed, and the AARN's beliefs about therapeutic nurse-client relationships. Upon initial registration, every nurse in Alberta receives several fundamental documents relating to standards of care and ethical behaviour. These seminal documents include the Nursing Profession Act of 1983, Nursing Practice Standards and Competencies (AARN, 1991), and the Canadian Nurses' Association (CNA, 1991) Code of Ethics for Nursing. Professional requirements for practice are met when the registered nurse demonstrates the skills, attitudes, and knowledge of therapeutic behaviours which are outlined in the AARN's practice standards and competencies (AARN, 1998).

Professional boundaries, those behaviors that separate therapeutic and nontherapeutic interactions, are a complex issue that must be afforded recognition by all nursing professionals. Expectations of conduct are established in many ways. For example, nursing professionals establish their own conduct. As well, licensing agencies and laws set forth by government establish conduct. When rules of conduct are not adhered to, the therapeutic relationship between the nurse and the patient breaks down, and boundary violations occur. Foundations for client care centre on trust, respect, intimacy, and power. All nurses must appreciate these bases underlying their relationships with clients (AARN, 1998).

According to the AARN (1998), clients trust the nurse to provide ethical and appropriate care. As well, the nurse treats the client with respect for his/her individual values and beliefs. Accordingly, the "nature of nursing practice creates an atmosphere of physical, emotional, and psychological intimacy" (p. 7) in which the relationship is one of unequal power. The nurse has authority, knowledge, and access to confidential information (AARN, 1998). It is the nurse's duty to maintain standards of professional conduct. Any act of abuse (verbal, physical, emotional, financial, neglect) by the nurse contravenes the nurse-client relationship and is a boundary violation.

There are clear warning signs that professional boundaries are in question or have already been transgressed, as identified by Coltrane and Pugh (1978); the Registered Nurses Association of British Columbia, British Columbia Council of Licensed Practical Nurses, and Registered Psychiatric Nurses Association of British Columbia (n.d.); and, Smith, Taylor, Keys, and Gornto (1997). These signs may include the following:

1. frequently thinking of the client when away from work,
2. frequently planning other clients' care around the client's needs,
3. spending free time with the client,
4. excessive self-disclosure by the nurse,
5. feeling responsible if the patient's progress is limited,
6. noticing more physical touching than is appropriate or sexual contact in interactions with the patients,
7. keeping secrets with the patient,
8. swapping patient assignments to be closer to the patient,
9. changing dress style for work when working with the client,
10. receiving gifts from the patient,
11. denying that the client is a patient, and
12. denying that the boundary has been crossed from a therapeutic to a nontherapeutic relationship (AARN, 1998).

Canadian authors Murray, Gillese, Lennon, Mercer, and Robinson (1996) provided a set of nine basic ethical principles "that define the professional responsibilities of university professors in their role as teachers" (p. 1). These nine general guidelines need to be taken into account when designing and analysing university teaching. The document is intended as "food for thought" (p. 1). The authors suggested that when these nine ethical guidelines are used, ambiguity concerning teaching responsibilities is greatly diminished. The nine ethical principles are as follows: content competence, pedagogical competence, dealing with sensitive topics, student development, dual relationships with students, confidentiality, respect for colleagues, valid assessment of students, and respect for the institution.

Content competence refers to the competence of the teacher in terms of being responsible for maintaining course material relevant to course goals or objectives. Furthermore, the teacher needs to be current in content areas relevant to his or her courses, familiar with course prerequisites, and capable to represent important topic areas and points of view (Murray et al., 1996). Pedagogical competence refers to communication of course objectives, awareness of alternative teaching methods, and the deliveries of course content in a meaningful manner. This principle implies that the teacher is well-versed in pedagogical knowledge. For example, the teacher communicates course objectives, selects effective instructional methods, provides practice and feedback opportunities, and accommodates for different learning styles of the students. The third principle, dealing with sensitive topics, deals openly and honestly with addressing topics that are sensitive or uncomfortable to students in a positive manner.

Principle four addresses student development. Murray et al. (1996) proposed that it is the teacher's responsibility to contribute positively to the student's intellectual development. The teacher's main goal is to develop course content that will facilitate learning and encourage autonomy and independent thinking in students. A main goal of the teacher is to focus on pedagogical goals and academic requirements. When the

teacher engages in a dual relationship, a conflict of interest results. This relationship is counterproductive and detracts from student development (Murray et al., 1996). In terms of confidentiality, student records, attendance records, and private communications, they are never to be discussed with anyone other than the student, unless written consent is obtained or if there are reasonable grounds for believing that releasing such information will be advantageous to the student or will prevent harm to others.

The seventh principle, respect for colleagues, is based on respecting the dignity of colleagues in the interest of promoting student development. Open and valid assessment of the student is of the utmost importance. This eighth principle touches the teacher's responsibility in fairly assessing the student in terms of congruence with course objectives. At the beginning of the course, the teacher reviews the course syllabus with the students, thereby alleviating any misconceptions about course content, teaching methods, communication of grades, and style of exams, assignments, or papers.

Respect for the educational institution is the ninth principle. The educational goals, policies, and standards of the facility are respected by the teacher. The teacher agrees to abide by the mission statement of the learning institution, the policies and regulations of the university, and the educational goals set forth by the university.

Summary

Preceptors have a professional and moral duty to teach and supervise students while serving as their role model. This professional relationship involves a power imbalance (Clark, 1998) and is not necessarily negative but, rather, benevolent in nature. The AARN (1998) set guidelines pertaining to professional boundaries within the nurse-client relationship. The teacher in terms of appropriate conduct between the student and teacher could use those guidelines.

CHAPTER IV

CONCEPT ANALYSIS

Concept analysis is a "careful examination and description of a word and its uses in the language" (Walker & Avant, 1995, p. 35). The ultimate goal of concept analysis is the acquisition of knowledge, while simultaneously defining a concept that is not already understood. According to Walker and Avant, there are eight steps in concept analysis:

1. Select a concept,
2. Determine the aims or purposes of analysis,
3. Identify all uses of the concept that you can discover,
4. Determine the defining attributes,
5. Construct a model case,
6. Construct borderline, related, contrary, invented, and illegitimate cases,
7. Identify antecedents and consequences, and
8. Define empirical referents.

Select a Concept

The initial step in concept analysis is selecting a concept. The concept to be analysed is preceptorship.

Determine the Aims or Purposes of Analysis

The second step in concept analysis is determining the aims or purposes of analysis. This step answers the question, "Why am I doing this analysis?" The main purpose of this analysis is to clarify the meaning of preceptorship. In addition, there is a wish that more knowledge will be added to the existing knowledge base of the nursing profession regarding this concept.

Identify All Uses of the Concept

The third step in concept analysis relates to identifying as many uses of the concept as possible (Walker & Avant, 1995). To achieve this, many information/ reference sources were utilised. For example, two etymology dictionaries were used, as were literature searches conducted via the Networking Edmonton's Online Systems (NEOS) Library system at a major Canadian university. Relevant literature was gathered from the following reference sources: Cumulative Index to Nursing and Allied Health Literature (CINAHL), Nursing Knowledge Network (NKN), MEDLINE, Psychlit, Web of Science Records, Law database, and ERIC.

All uses of the term *preceptorship* were considered; hence the literature from other disciplines was explored, such as literature pertaining to nursing, medicine, law, psychology, rehabilitation, dentistry, pharmacy, social work, engineering, and education. The search terms utilised were preceptor, preceptorship, clerkship, paradigm, model, framework, supervisor, field educator, articling, internship, clinical educator, teaching, education, teaching methods, law education, medical education, teacher education, clinical supervisor, mentor, and apprentice.

To lend validity and credibility to this concept analysis, the root meanings of preceptor, mentor, and apprentice were determined using two etymological dictionaries (Klein, 1971; Skeat, 1958).

Preceptor

According to Klein (1971, p. 583), *preceptor* is a noun meaning "teacher." This term is derived from the Latin word *praeceptor*, which means "teacher, instructor." A possible earlier form of *praeceptor* is *praecipere*, which means "to give rules, advise, teach." Precept, a noun, is derived from the Latin word *praeceptum*, which means "rule, maxim." The prefix root *prae-* (or pre-), from the Latin language, means "before" (both

in time and place). Likewise, the suffix root *-capere* also comes from the Latin language and means "to take."

Skeat's (1958) dictionary stated that the word *precept* comes from the Latin language and means "a rule of action, commandment, maxim" (p. 470). A derivative of precept is *praeceptor*, which means "a teacher." The Latin word *praecipere* is defined as "to take beforehand; to give rules." The prefix root *prae-* is a Latin word meaning "before," and the suffix root *-capere*, also from the Latin language, means "to take."

Mentor

Klein's (1971) etymological dictionary defined *mentor* as "a wise adviser" (p. 457). This word is derived from the Old Indian word *mantar*, which means "one who thinks." The Latin derivative is *monitor*, which means "one who admonishes." The word *monitor* comes from the Latin word *monitus* (past participle of *monere*), which means "to advise, warn, admonish." The root prefix *men-* comes from an Indo European lineage and means "to think," and the root suffix *-tor* is derived from the same lineage and is "a masculine agential suffix."

Skeat (1958, p. 371) stated that *mentor* comes from the Greek language and means "an adviser, monitor." This word is adopted from the story of Homer, in which Athene takes the form of m*entor* with a view to giving advice to Telemachus. Skeat stated that *mentor* is equivalent to the Latin word *monitor*.

Apprentice

Klein (1971, p. 45) stated that the word *apprentice* is derived from the Middle English word *aprentis*, which means "to learn, teach." *Aprentis* comes from the Latin word *apprehendere*, which means "to seize, take hold of, grasp, apprehend." Skeat (1958) defined apprentice as "a learner of a trade" (p. 27), which is derived from the French and Latin languages. The Latin word *apprendere*, a short form of *apprehendere*, means "to lay hold of."

In terms of overlap, the concepts of preceptor and mentor overlap somewhat. The concept of apprentice does not relate to the teaching and learning process of the student nurse or the new employee. When referring to a teaching and learning relationship and a program of instruction, preceptor remains the better choice of concept than mentor. However, the concept of mentor has merit. The term means a wise advisor, implying that the teaching and learning relationship is not focal, but rather that a more collegial, nurturing relationship may occur.

Review of the Multidisciplinary Literature

To grasp the concept of preceptorship, a multidisciplinary literature review was undertaken. The development of nursing theory does not occur in a vacuum. Rather, there are fundamental elements or building blocks needed to develop nursing theories. Basic elements for theory construction are concepts, which are mental images of a construct (Walker & Avant, 1995). An approach to theory building is via analysis. When analysis occurs, clarification of a concept is the result. In essence, a whole is divided into its elemental parts so that they can be better understood (Walker & Avant, 1995). When analysing the concept of preceptorship, the seven research questions are clearly addressed and subsequently answered.

Walker and Avant (1995) stated that a review of the literature "helps to support or validate your ultimate choices of the defining attributes" (p. 40). Indeed, failing to explore and identify some uses of the concept may result in an analysis devoid of important descriptions or severely limiting the usefulness of the outcome. Regarding the discipline of nursing, there is a plethora of articles exploring the concept of preceptorship, usually in a clinical setting.

Kaviani and Stillwell (2000) reviewed the apparent differences between mentorship and preceptorship. This difference is explicit. Whereas the preceptor is more concerned with the teaching and learning aspects of the relationship, the mentor aims for

a more personal relationship. Preceptorship focuses more closely upon adult education principles and is "therefore a more effective means of learning than that proposed through the mentorship approach" (p. 219). Important components of preceptor education include teaching and learning strategies and theories, principles of adult education, communication skills, conflict resolution, assessment of individual learning needs, and evaluation of neophyte performance. Kaviani and Stillwell noted that preceptorship has been shown to be an effective way of bridging the theory-practice gap in nursing.

Kaviani and Stillwell (2000) described their research pertaining to an evaluative study of clinical preceptorship. The objectives of this clinical preceptorship were to help registered nurses to effectively integrate, support, and assist the development of clinical competence in undergraduate-nursing students. A research study was conducted to evaluate the program's effectiveness following the implementation of the preceptorship programme. Using two focus group interviews, the researchers examined the preceptors', preceptees', and nurse managers' perceptions of the preceptor role and factors that influenced the performance of preceptors. Twenty-one subjects were used: six preceptors, 13 third-year nursing students, and two nurse managers from the clinical and nurse education settings.

Kaviani and Stillwell (2000) advised that preceptors must be educationally prepared for this role and subsequently supported and rewarded by faculty and their peers. Further, it cannot be assumed that because a nurse is an expert in the field, he/she can automatically function as a preceptor. Desirable personal characteristics of a preceptor include self-confidence, motivation, enthusiasm, knowledge and expertise, and being a lifelong learner. In a perfect world the responsibility to educationally prepare a preceptor for the role might be via both the preceptor and the health care facility. If the facility requires prepared preceptors, then the facility should take on some of the educational responsibility by either paying for courses or workshops or paying for

educational material. Likewise, the preceptor has an obligation to take responsibility to prepare him/herself to be a preceptor.

Clinically focused seminars with a practicum are a method used by one school of nursing to better prepare nursing students in their final year for their soon-to-be new role as neophyte graduate nurses. Mills, Jenkins, and Waltz (2000) detailed how this program works. Courses begin and end with a one-credit seminar and include one three-credit clinical practicum. In the practicum, students work with a clinical preceptor, following the preceptor's work hours for a minimum of nine hours a week over a 15-week period. Initial emphasis areas include critical care, gerontology, women's health, and oncology. These areas were expanded to all clinical areas of study such as adult, maternal, child, community, and mental health. These students ultimately learn skill development, patient care management, and interdisciplinary teamwork, which prepares them for the realities of the work environment.

LeGris and Cote (1997) described five important steps in the process of establishing and maintaining a nursing student preceptor programme in a psychiatric unit. Clinical preceptorship programs continue to grow in popularity as a "collaborative method of nursing education for nursing students" (p. 55). Hayes (1994), Myrick and Barrett (1992), and Pond, McDonough, and Lambert (1993) supported this. Furthermore, preceptorship experiences provide a one-to-one clinical learning experience with a role model. It is interesting to note that the majority of baccalaureate nursing students in Canada are working with diploma-prepared nurse-preceptors (Myrick & Barrett, 1992), but they should, instead, be working with preceptors prepared at the same or at a higher level than students (Myrick & Barrett, 1994). LeGris and Cote's five steps and processes of developing and implementing a preceptorship program are as follows: (a) initiating linkages, (b) selecting and preparing learning partners, (c) bridging the theory-practice gap, (d) evaluating/modifying, and (e) acknowledging and reciprocating benefits.

According to Schoener and Garrett (1996), preceptorship is acknowledged as a clinical teaching strategy which eases the transition of nursing students from the educational setting into the practice realm. They posited that the role of faculty is important for the successful completion of preceptorship experiences. Faculty serve as support for the student and the preceptor in selecting the preceptor based on specific attributes, orientating the preceptor and providing the initial education for the student nurse, and the preceptor is responsible for the clinical supervision of the student. The faculty also evaluates the student but must acknowledge the need to be evaluated as well. The faculty member has the task of fully developing the course.

Ferguson (1995) explored faculty roles in supporting precepting nurses through a qualitative study. Thirty participants were ultimately randomly selected from an initial study population of 103 nurses. This qualitative study utilised grounded theory to examine the issues and concerns surrounding preceptor evaluation of student clinical performance. Thirty clinically experienced nurses were preceptors for BScN students in their third year of a four-year program at a western Canadian university. The preceptorships comprised four- to five-week clinical experiences. Five themes emerged from the study: (a) faculty accessibility, (b) provision of information, (c) evaluation of student performance, (d) student advocacy, and (e) mentorship to the preceptor. When taken together, the five themes "form an expectation of ideal faculty support" (p. 48).

Coates and Gormley (1997) conducted a case study involving 62 preceptors, 15 nursing students, four ward managers, two senior nurse managers, and eight nurse teachers. The investigation was centred on enhancing clinically based learning by means of preceptors. The results indicate that preceptors believed that functioning as a role model and acting as a student-supervisor, but not assessing the student, were part of their role. Coates and Gormley also posited that just because practitioners are knowledgeable and experts in their field, this does not mean that they can automatically function as a

preceptor. Indeed, the role of the preceptor must be clarified, and sufficient resources to facilitate student/preceptor learning are required.

Cohen and Musgrave (1998) described a preceptorship program in an Israeli bone marrow transplantation (BMT) unit that allowed students and new nurses the chance to familiarise themselves with this threatening and unknown nursing environment. This preceptorship program encompassed three aspects: (a) a comprehensive medical knowledge base; (b) instruction in special nursing skills, aimed at meeting both the physical and psychological needs of BMT patients/families; and (c) supervised involvement in patient and family education and counselling. Cohen and Musgrave stated that the role of the preceptor comprises four elements, which are to act as a role model, demonstrate good teaching skills and the ability to give effective feedback, act as a supervisor, and provide support. The BMT preceptorship offers two types of education programs: a short-term program and an advanced 10-week clinical experience. The short-term program is made available to several groups of students that include third-and fourth-year nursing students, nurses attending the intensive care course, and those taking the advanced oncology course. The advanced 10-week clinical course is offered to fourth-year nursing students in their final semester to allow them to bridge the gap between life as student nurses and the reality of becoming neophyte graduate nurses. Because the feedback from the BMT program preceptorship was very positive, recruitment to working on this unit was fostered.

Byrd, Hood, and Youtsey (1997) utilised a survey method to elicit factors important in the development of a successful learning partnership. Surveys were sent to 61 registered nurses who served as preceptors to nursing leadership students. Thirty-three preceptors returned the completed surveys. Surveys were distributed to 42 undergraduate nursing students, and 40 students completed the surveys. Through interpretation of the data, it became clear that students and preceptors approach the learning partnership from very different perspectives. Differences were evident in values, communication styles,

and unclear expectations. Preceptors noted as important factors to foster an effective student/preceptor relationship (a) the ability to give and receive constructive feedback, (b) clinical competence, (c) knowledge of objectives, (d) motivation, (e) communication skills, (f) clinical competence, and (g) flexibility.

Medicine

According to Fernald et al. (2001), the discipline of medicine has undergone significant changes that are affecting the content and process of medical education. In response to these changes, community-based learning experiences, such as preceptorships in primary care settings, have become more popular within medical schools. Focus groups were conducted over a three-year study with medical students to describe the aspects of preceptorship that enhance the learning environment and maximise the utility of preceptorships for students. The purpose of this research was to identify from a student's perspective important context and process issues in a longitudinal preceptorship. The data identified the themes important to making the preceptorship effective for students. The main themes that emerged included active teaching, active learning, a trusting relationship, sufficient time, and a shared understanding of preceptorship objectives. Potential benefits to the students include comfort, confidence, responsibility, skills, knowledge, reinforcement, learning opportunities, teaching opportunities, and models for practice.

Kernan, Lee, Stone, Freudigman, and O'Conner (2000) surveyed experienced medical students to ascertain their opinions on effective teaching behaviours. Nine focus groups were held at Yale and Tufts Universities and targeted third-year medical students who had completed one-month rotations in ambulatory care internal medicine. Of the 150 medical students who volunteered to complete the survey, 122 returned it. The teaching behaviours identified as favourable and those which preceptors should possess included orienting to the rotation, creating a favourable learning environment, overseeing the

student's experience, organizing patient-student interactions, teaching clinical skills and knowledge, and providing feedback.

Epstein, Cole, Gawinski, Piotrowski-Lee, and Ruddy (1998) described their study that was conducted to help community-based physicians/preceptors who teach medical students recognise and build on effective education strategies. Thirty-seven narratives were completed, representing 100% of the medical students taking the clerkship in Rochester during the 1994-95 academic year. This study was conducted to document students' self-identified important learning events during a fourth-year family medicine clerkship. Epstein et al. (1998) stated that many community-based physician faculty have had limited training in teaching in the ambulatory setting. Several different modes of learning emerged from the 37 student narratives, including observational and collaborative learning, coaching, discussion outside of the examination room, advocacy, and affective education. Upon analysing the 37 narratives, it was noted that active observation was the prevalent form of learning utilised by these medical students. Preceptors are being observed more than they may realise.

In terms of teaching medical students palliative medicine, the range of teaching staff is widening to include general practitioners, hospice doctors, oncologists, and nursing staff. Barrington and Murrie (1999) conducted a prospective, descriptive pilot study to develop a teaching model that would provide undergraduate medical students with a period of contact with terminally ill patients. Twenty medical students in their fifth year worked with nurse-preceptors during three standard morning shifts, allowing the student to interact with terminally ill clients and families at several levels. The nurse-preceptors reported high satisfaction levels not only with the project, but also with their role and the level of individual student enthusiasm and participation. This pilot study demonstrates that "providing experiential opportunities for medical students may have positive influences on learning and skill development" (p. 43).

Kilminster and Jolly (2000) conducted a large-scale, interdisciplinary review of the literature addressing clinical supervision, in terms of clinical education of postgraduate and undergraduate medical students. The purpose of the literature review was to identify what is known about effective clinical supervision. Kilminster and Jolly observed that there were few empirical studies about supervision. The literature review included relevant literature from other disciplines, such as nursing, social work, teaching, psychology, and counselling. There is little discussion of theoretical models in the medical literature. However, Bowen and Carline (1997) posited that social learning theory describes the process of professionalization. Kilminster and Jolly stated that the nursing literature tended to provide more narrative and philosophical supervisory models with little or no empirical basis. Literature relevant to counselling, psychotherapy, social work, and nursing sources "contain most discussion of models and theoretical approaches to supervision" (p. 829).

According to Kilminster and Jolly (2000), most supervisory models stress the need to use approaches that are appropriate to the trainee's level of experience and training. There is limited empirical support for this proposition. They further suggested the following about supervisors. They need (a) to be clinically competent and knowledgeable and have good communication skills; (b) be able to link theory and practice; (c) give constructive feedback; (d) be a role model; (e) be supportive, flexible, direct, and tolerant; and (f) understand teaching, assessment, and counselling skills.

Pharmacy

The discipline of pharmacy utilises the concept of preceptorship. Vrahnos and Maddux (1998) developed an introductory clinical clerkship course which involves students in patient care activities early in their academic experiences, introduces students to clinical communication and organisational skills, helps bridge the theory-practice gap, and provides opportunities for the students to practice clinical and scientific writing

skills. During the clerkship each student was required to develop a "Clerkship Portfolio" that would allow both the student and the preceptor to track student performance throughout the rotation. The preceptor was a member of the clinical faculty.

To further support the knowledge that the discipline of pharmacy utilises the concept of preceptorship, Catney, Arthur, Fleckenstein, and Scavone (1998) described a clerkship that integrated pharmacy student clinical activities into a Visiting Nurses Association office and established a mechanism for supervision by off-site preceptors. The clerkship provided rich opportunities for student growth and pharmacy service development and was successfully managed by off-site preceptors. The preceptors were two pharmacy faculty members who agreed to collaborate in this venture.

Rhoney, Brooks, Patterson, and Pieper (1998) reported on a survey that assessed preceptor and fellow attitudes, expectations, activities, and recommendations for pharmacy fellowships. Approaches for preparing postgraduate pharmacy fellowship practitioners vary amongst programs. It has been determined that "a pharmacy residency is an organised, directed, postgraduate training program in a defined area of pharmacy practice. A pharmacy fellowship is a directed, highly individualised, postgraduate training program designed to prepare the participant to become an independent researcher" (p. 290). A preceptor is an experienced and highly recognised pharmacist with a recognised research portfolio, whereas a fellow holds a Doctorate in Pharmacy degree.

Matzke, St. Peter, and Foote (2000) carried out a survey that consisted of health system pharmacists participating in a nephrology pharmaceutical care preceptorship (NPCP) to determine the impact of the program. The research study involved 145 pharmacists, each of whom was preceptored with a faculty member from the University of Pittsburgh pharmacy program. In summary, pharmacy utilizes not only the concept of preceptorship, but also the concept of clerkship.

Law

One method of education that the domain of law utilises to teach the practicalities and realities of the profession to students is through articling. According to Hutchinson (1994), during the 13th century in England students were taught about legal lore and the legal system. For English lawyers a more formalised version of this apprenticeship is still in practice. Hutchinson described articling as a rite of passage rather than a structured mode of learning the realities of law. He believed that articling should be abolished, as it has been done in many of the states.

All aspects of legal education should and can contribute to the development of law graduates, the majority of whom continue to become legal practitioners (Zemans, 1988). Articling consumes approximately 20% of a future lawyer's legal education (Zemans, 1988). Amongst the law schools and the profession as a whole in Ontario, there have been many debates as to how to strike a balance between the practical and theoretical approaches to legal education. Zemans talked at great length about the educational option of clinical legal education rather than articling. In summary, the domain of law uses a very different concept when educating their students. The concept used is articling, and is more like apprenticeship than of preceptorship. However, there is some debate amongst the legal education system whether articling should be substituted with some other form of educational modality.

Social Work

Raschick and Maypole (1998) explored ways in which the application of Kolb's learning theory can improve the quality of field education in social work. Field education is utilised in social work to allow the student to learn hands-on in the community setting; this is the application of theory in the practice setting. Students are placed in the community agency under the watchful guidance of an agency supervisor. This supervisor is then responsible for assessing the student's knowledge, values, skill levels, and

developmental maturity and devises a learning plan for that student. Ganzer and Ornstein (1999) further supported the belief that field instruction "is the centrepiece of social work education, providing an experiential overlay to theoretical underpinnings of practice" (p. 231). Ganzer and Ornstein stated that an important component of field instruction is the relationship between the knowledgeable and experienced field instructor and the student because the supervisor acts as a role model and helps to lay the foundations for the student's "professional self" (p. 231). Like law, the discipline utilises a different concept to describe student learning. Instead, *field education* is the term used when describing the teaching-learning milieu.

Rehabilitation

Within the rehabilitation milieu, physiotherapy utilises the concept of clinical educator. Cross (1994) discussed some effects of professional development on clinical education. Since the 1960s the profession has undergone significant changes in terms of curriculum development and education of students. The 1980s saw professional autonomy take hold; specifically, degree-based programs were established. Teachers took on the role of teachers of students in the field, and drilling the students was no longer the norm. Rather, active teaching in a wide variety of educational settings was done. The 1990s saw the profession expand towards a less formal and traditional means of student education. *Clinical educator* is the term now used to describe the clinician responsible for student field education. These educators help the student bridge the theory-practice gap. The term clinical educator now replaces the term clinical supervisor. The clinical educator's role encompasses the following attributes: They nourish the student, actively participate in student learning, are approachable, display self-disclosure and respect, and are mentor and facilitators. Walker and Openshaw (1994) used the terms clinical supervisor and clinical educator to describe the relationship between the field (clinical) educator and the student. A survey approach was used to determine the perceived needs

of physiotherapy clinical supervisors. One problem noted in the physiotherapy literature is the lack of preparation for the role of clinical supervisor (Scully & Shephard, 1983). Christie, Joyce, and Moeller (1985) supported this statement and felt that clinical experience alone does not mean that a practitioner can become a supervisor and teacher of physiotherapy students. When practitioners are adequately prepared to teach physiotherapy students, the gap between theory and practice can be bridged. Formal education of clinical educators, improved communication, input from students, and evaluation of students are deemed important factors in educating physiotherapy students.

Onuoha (1994) conducted a study in the United Kingdom to identify behaviours of clinical supervisors that were perceived as most effectual in facilitating learning in the clinical setting. Participants in the survey were physiotherapy students, clinical supervisors, and teachers. Highly regarded attributes displayed by the supervisors were clinical competence, knowledge about the clinical area, and good communication skills. Even though clinical supervisors are expected to impart clinical skills to students, most of them are not formally prepared in teaching and evaluation. Scully and Shepherd (1983) and Neville and French (1991) concurred. Additional attributes modeled by clinical supervisors are the following: (a) role modeling, (b) sound theoretical and practical bases, (c) good time management, (d) leadership, (e) good interpersonal skills, (f) problem-solving skills, (g) enthusiasm, (h) allowing students to observe them in the clinical setting, (i) accessibility and approachability, (j) concern for patient welfare and student learning, (k) respect, (l) provision of useful feedback, and (m) evaluation of students.

Hagler and McFarlane (1991) suggested that the leadership and educational skills "that help business leaders guide their employees to be successful money-makers look amazingly like desirable clinical educator skills" (p. 5). The authors suggested that the concept of supervisor might not be adequate in describing the relationship between the rehabilitation educator and the student. Rather, the concept of coaching might be more appropriate. There are five coaching roles that are discussed in terms of occupational

therapy, physical therapy, and speech-language pathology: educator, coach, sponsor, counsellor, and confronter. Coaching supports a process of continuing learning that enables the rehabilitation student to reach their full potential. The coach recognizes that although not all students are excellent and that even exceptional students can perform poorly, the effort and time must be extended by the supervisor coach so that the students have the opportunity to reach their goals.

In summary, the rehabilitation disciplines use different terms when describing the teaching/learning domain; for example, the terms clinical educator, clinical supervisor, and supervisor coach.

Dentistry

After an extensive search of the dentistry literature, little literature was found pertaining to the education of dentists. Specifically, there was little literature addressing how dental students are taught and what role the educator plays. Loevy and Kowitz (1998) discussed women entering dentistry. In the early 19th century people were settling in the Middle West of the United States, and soon afterwards dental schools were beginning to be established. With the establishment of the schools, the profession soon evolved from a "craft transmitted by a preceptor to a profession taught within established schools" (p. 89).

Clinical Psychology

In terms of clinical psychology, Milne and Oliver (2000) talked about a mode of clinical mental health education known as clinical supervision. As with dentistry, there was little literature discussing or researching how mental health students were taught, what role the teacher played, and what teaching techniques were used. Milne and Oliver stated that few supervisors have received any formal education in supervisory methods. Robiner and Schofield (1990) supported this. Milne and Oliver defined clinical

supervision as an evaluative relationship between a senior member of a profession and a junior member or members of that profession, with the relationship extending over time.

Education

The discipline of education, like the discipline of nursing, has a well-developed literature base describing similar concepts to preceptorship. Ganser and Wham (1998) described the professional contributions and personal satisfaction of co-operating teachers. They suggested that student teaching has been a pivotal feature in the preparation of student teachers. Sudzina, Giebelhaus, and Coolican (1997) also supported this idea. When in the field, the student teacher is under the guidance of an experienced and knowledgeable teacher. This expert teacher is called a *co-operating* teacher. The co-operating teacher influences the novice student teacher, either in a positive or a negative manner.

Ganser and Wham (1998) based their paper on data/information from a survey of co-operating teachers serving in the teacher education program of a mid-Western comprehensive university. The 454 respondents (response rate of 67%) included preschool teachers to high school teachers and special education teachers. The survey had three sections. Ganser and Wham focused on a content analysis of the teachers' responses to the following two questions: (a) What is the greatest contribution a co-operating teacher can make in preparing a future teacher? and (b) what is greatest satisfaction for a co-operating teacher? Ganser and Wham analysed the respondents' comments and found that co-operating teachers believed that they contributed to the professional preparation of future teachers. Co-operating teachers felt that they had a duty to provide teaching students with real-life classroom experience, serving as role models and assisting the novice in mastering basic teaching skills.

Smith and Souviney (1997) utilised the concept of internship to describe teacher education. They briefly described the historical preparation of neophytes for membership

in critical professions. Smith and Souviney touched briefly on apprenticeships in terms of preparation of professionals prior to the industrial revolution. Although the authors likened internship to apprenticeship, they made the distinction that internships "are generally associated with professions that require complex decision making skills and expertise in more than one discipline" (p. 6), such as veterinarians, teachers, architects, and physicians. In the United States, internship programs for teacher education appeared in the early 1950s. Each intern is assigned a university supervisor who then, over a two-year period, develops a mentoring relationship with 8 to 12 interns.

The Diploma in Art Education program at Concordia University, Montreal, Quebec, conducted a survey of its co-operating teachers to ascertain their insights and suggestions regarding the teacher-training process. Langdon, Weltzl-Fairchild, and Haggar (1997) reviewed the findings of the Concordia University survey and "examine[d] common issues in the mentoring of student teachers that concern all disciplines in education as well as those particular to art education" (p. 46). Langdon et al. (1997) defined co-operating teachers as full-time teachers who tutor or mentor student teachers or novice teachers. Common names often associated with full-time teachers who mentor or tutor the neophyte student or teacher are master teacher, mentor, associate, or co-operating teacher. Regarding the survey, seven co-operating teachers were interviewed over a three-month period about the role, benefits, problems, and incentives of accepting the role. They were also asked about the implications of these elements for the student teacher's practicum experience. All seven co-operating teachers held similar beliefs about their role. The terms advisor, guide, providing a hands-on experience, bridging the theory-practice gap, role model, facilitator, supporter of personal development, and mentor were utilised to some degree by all seven subjects. Benefits included having "an extra pair of hands around" (p. 51) and learning new ideas and approaches to teaching. A strong incentive for co-operating teachers to act in this role pertained to financial compensation as a form of recognition. Other incentives included

professional development and public recognition. However, one major problem that surfaced was matching the schedule of the co-operating teacher with that of the student. Another spoke to the issue of student orientation. Three of the co-operating teachers recommended that student teachers be orientated before they start their practicum.

Sudzina et al. (1997) addressed the failure of a student teacher. An assumption made by preservice teachers and education faculties is that the co-operating teachers in practicums act as mentors, helping them to bridge the theory-practice gap. However, whether due to miscommunication or misunderstanding about expectations, this mentor relation sometimes does not develop. Instead, a tormentor relationship develops. This preliminary study by Sudzina et al. described and explored expectations, perceptions, and qualities of mentoring relationships between co-operating teachers and student teachers at two education institutions in the United States.

Roles deemed necessary for a mentor to assume are supporter, sponsor, guide, counsellor, protector, encourager, and confidant; who offers thoughtfulness, organisation, a sense of humour, integrity, an outgoing personality, effective communication, and knowledge about the mentee's developmental needs (Sudzina et al., 1997). Also fundamental for a successful mentor-mentee relationship and a successful practicum is that the co-operating teacher be adequately prepared academically and orientated to the role. Harwood, Collins, and Sudzina (2000) concur. Sudzina et al. further posited that specific supervision and mentoring training be undertaken; thus they proposed a three-phase program addressing three main topics: goals and expectations, roles and responsibilities, and the supervision process. This study suggests that co-operating teachers tend to function more as advisors to the student teacher rather than as mentors.

Clarke (2000) presented a follow-up study pertaining to an advisory practicum for practicum advisors. For 15 years a voluntary credit course for classroom teachers who wished to learn about and prepare for their work as practicum advisors has been offered at the University of British Columbia (UBC), Vancouver, Canada. Clarke outlined a

study, using a survey, to determine whether the influences initially reported by the advisors in their practicum have endured over time.

Studies by Dart and Drake (1993) and Painter and Brown (1979) have shown that practicum advisors are not adequately prepared for their role with student teachers. However, Clarke (2000) believed that the practicum is critical to the success of preservice teacher education. This was also supported by Sudzina et al. (1997).

Several themes emerged from the survey pertaining to listening to the student and encouraging student teacher ownership of practice, careful planning of pre- and post-lesson conferences, and thinking about and discussing teaching. In terms of the long-term influences of the advisory practicum, three themes occurred throughout the advisors' responses. First, the advisory practicum was viewed as a form of guided practice. Second, the practicum provided an opportunity for self-reflection on philosophies and about teaching practices. Finally, the interactive nature between the student teacher and the practicum advisor was explored. One notable long-term result of this study was that the teachers who completed the advisory practicum now viewed their work with student teachers as a mutual professional development relationship.

Wang (2001) described a study in which data from 23 United States, United Kingdom, and Chinese mentor teachers explored the relationship between contexts of mentoring and mentoring practice. It discussed learning opportunities created by mentoring in different contexts for student teachers to learn to teach. When learning institutions are designing mentoring programs and arranging mentoring relationships, "teacher educators need to consider how to restructure school contexts and help mentors learn how to mentor" (p. 51). When mentor teachers are selected, it is important to consider the relevant teaching experience of mentors. It is also important to clearly identify how mentors conceptualise mentoring and their relevant experience in conducting the kind of mentoring practices expected.

In terms of educating the education student, the discipline of education widely uses the concepts of co-operating teachers, mentor, mentorship, and teacher education. Defining attributes deemed valuable by the student teacher of the co-operating teacher include to act as facilitators and role-models, provide reality-based learning, help to bridge the theory-practice gap, foster independence, provide support, provide mentorship and feedback, have good communication skills, and be academically prepared for the role.

Summary

In comparison to other disciplines, the discipline of nursing has developed a highly structured definition for preceptorship, utilising the concept in the education of neophyte nursing students and new employees. Kaviani and Stillwell (2000), LeGris and Cote (1997), and Ferguson (1995) suggested that preceptors need formal academic preparation for this role. Schoener and Garrett (1996) similarly stated that preceptors need to be adequately orientated. LeGris and Cote, and Ferguson further stated that the majority of Canadian BScN students are preceptored by diploma-prepared nurses who may therefore lack the teaching background necessary to function effectively as a preceptor. Coates and Gormley (1997) added that just because nurses are knowledgeable and expert in their field, it does not mean that they can automatically function as preceptors.

Functions and behaviours commonly mentioned specific to the preceptor role are as follows: (a) role model (Coates & Gormley, 1997; Cohen & Musgrave, 1998; Kaviani & Stillwell, 2000; LeGris & Cote, 1997; Schoener & Garrett, 1996); (b) facilitator (Kaviani & Stillwell, 2000); (c) socialises students into a new role (Cohen & Musgrave, 1998; Ferguson, 1995; Kaviani & Stillwell, 2000; Mills et al., 2000); (d) supports, (Cohen & Musgrave, 1998; Ferguson, 1995; Kaviani & Stillwell, 2000; Schoener & Garrett, 1996); (e) needs to be recognised, (Kaviani & Stillwell, 2000; LeGris and Cote,

1997); (f) clinically competent and knowledgeable (Byrd et al., 1997; Coates and Gormley, 1997; Ferguson, 1995; Schoener & Garrett, 1996); (g) good communication skills (Byrd et al., 1997; Coates & Gormley, 1997; Cohen & Musgrave, 1998; Ferguson, 1995; Schoener & Garrett, 1996); (h) good teaching skills (Cohen & Musgrave, 1998; Ferguson, 1995; Kaviani & Stillwell, 2000; Schoener & Garrett, 1996); (i) gives effective feedback (Byrd et al., 1997; Cohen & Musgrave, 1998; Ferguson, 1995); (j) provides evaluation (Ferguson, 1995; Schoener & Garrett, 1996); and (k) bridges the theory-practice gap (Kaviani & Stillwell, 2000).

The majority of the medical literature reviewed utilised the concept of preceptorship; however, the terms trainee, supervisor, and clinical clerkship were also used. The functions and/or behaviours of the medical doctor-preceptor deemed necessary for preceptorship to be successful are as follows: (a) teacher (Kernan et al., 2000); (b) provides feedback (Kernan et al., 2000; Kilminster & Jolly, 2000); (c) clinically competent and knowledgeable (Kilminster & Jolly, 2000); (d) role model (Barrington & Murrie, 1999; Kilminster & Jolly, 2000); (e) good communication skills (Barrington & Murrie, 1999; Kilminster & Jolly, 2000); (f) understand teaching principles (Kilminster & Jolly, 2000); (g) provides favourable, real-life experiences (Barrington & Murrie, 1999; Kernan et al., 2000); and (h) links theory with practice (Kilminster & Jolly, 2000).

Summary of the Literature Review

Whereas the literature pertaining to nursing and medicine has been clear about the definitions and/or uses of preceptorship, the pharmacy literature has been less so. Terms such as clinical clerkship, preceptors, preceptorship, clerkship, and pharmacy fellowship predominated in the pharmacy literature. Pharmacy uses clerkships (Carter, Draugalis, Slack, & Cox, 1998) to introduce the student to the realities of the profession. Faculty supervisors are utilised as preceptors to introduce the student to patient care activities

(Vrahnos & Maddux, 1998). Specific educator behaviours or characteristics have not been explicitly discussed or documented.

The discipline of law uses the concept of articling when describing education of the law student. However, actual behaviours or characteristics of the lawyer(s) under whom the student articles have not been discussed in the reviewed literature. The term apprenticeship has also been utilised with regard to student education; but again, behaviours and characteristics of the educators were not discussed.

In terms of the education of social work students, the concepts of field education, field instruction, and field educator are predominantly used. Again, there has been little description of attributes or admired behaviours of the educators. Cooper and Crisp (1998) stated that field education is regarded as a pivotal feature of social work education by providing individualised learning experiences for students. Field educators provide reality-based education frequently without reward or adequate recognition.

The discipline of rehabilitation, like nursing and medicine, describes educator behaviours more fully compared to the law and social work fields. Rather than preceptorship, concepts used include clinical educator, clinical supervisor, and clinical teacher. Behaviours of educators deemed important are as follows: (a) facilitator (Cross, 1994); (b) formally educated as a supervisor (Walker & Openshaw, 1994); (c) evaluates students (Onuoha, 1994; Walker & Openshaw, 1994); (d) clinically competent and knowledgeable (Onuoha, 1994); (e) approachable (Cross, 1994; Onuoha, 1994); (f) respectful (Cross, 1994; Onuoha, 1994); (g) mentors (Cross, 1994); (h) good time management and problem-solving skills (Onuoha, 1994).

In an article, Loevy and Kowitz (1998) used the term preceptor, but the article did not describe how dental students are taught or what educator behaviours the student deems favourable. No articles were found that discussed the education process of the dental student. Similarly, the mental health literature does not appear to adequately, or systematically, address teaching of students. Milne and Oliver (2000) utilised the concept

of clinical supervisor in terms of the education of clinical psychologists, noting that few supervisors have received formal education in supervisory methods.

In terms of preparing and educating student teachers, the education literature has been explicit in the use of the term co-operating teacher (Caruso, 1998; Croker, 1999; Ganzer, 1996; Ganser & Wham, 1998; Hamilton & Riley, 1999; Justen & McJunkin, 1999; Koster, Wubbels, & Korthagen, 1998; Langdon et al., 1997; Smith & Souviney, 1997; Wepner, 1999; Wilder, 1999). Other concepts utilised in terms of educating teachers include the following: internship (Hamilton & Riley, 1999; Smith & Souviney, 1997); mentoring relationship (Smith & Souviney, 1997); and mentor (Clifford, 1999; Cochran-Smith, 2000; Fletcher, 1998; Langdon et al., 1997; McCorkel, Ariav, & Ariav, 1998; Sudzina et al., 1997; Wilder, 1999). Other concepts noted in the education literature are master teacher (Langdon et al., 1997); practicum advisor (Clarke, 2000); teacher educator (Cochran-Smith, 2000; Willis, Thompson, & Sadera, 1999); and teaching apprenticeships (Willis et al., 1999).

Teacher attributes or characteristics deemed important by the education student are nurturer, expert colleague, role model, facilitator, encourager of reflection, curriculum developer, researcher, and stimulator of professional development. Other equally important attributes of student educators are that they are team members and collaborators and give personal support and feedback, liaise with teacher-education colleagues, help to bridge the theory practice gap, provide practical field experience, and have good communication skills.

CHAPTER V

THE MODEL

Determine the Defining Attributes

The fourth step in the concept analysis of preceptorship is to determine the defining attributes of the concept. Upon a review of the literature pertaining to the disciplines of nursing, medicine, law, rehabilitation (physiotherapy), social work, dentistry, clinical psychology, pharmacy, and education, the following educator behaviours/characteristics consistently appeared and were deemed favourable by students: They are role models and facilitators, they are academically prepared for the preceptor role, they are evaluators, they need support and reward, and they are clinically skilled and knowledgeable. Other behaviours and/or characteristics perceived by students as favourable are having knowledge about the principles of adult education, the ability to give feedback, and good communication skills. Walker and Avant (1995) stated that defining attributes are not constant; rather, they may change as the understanding of the concept changes or improves.

Construct a Model Case

Construction of a model case is the fifth step in the concept analysis of preceptorship. A model case is a pure example of the use of the concept that includes all the critical attributes of preceptorship (Walker & Avant, 1995). In other words, this is a "real-life" example of the concept. It is a paradigm.

Case Scenario: Preceptorship and Boundary Issues in an Isolated Community

During the summer of 1998, while she worked as an acting nurse-in-charge in a northern community, there was an opportunity for an experienced Bachelors of Nursing-prepared outpost nurse (DeDe) to become a preceptor to a third-year university nursing student (Steve) from a major Canadian university. Once in the community, the student stayed for a total of approximately two months. In this case, a northern nurse with a total

of 12 years' nursing experience had been working in isolated communities for three years when she was introduced to preceptorship issues while precepting this student. Once in the community, DeDe ascertained how best Steve learned and adapted her teaching style to what Steve described in the following way: Steve best learned by seeing something done initially, then doing it as a return demo. DeDe knew that young adults had their own personal knowledge that was of worth and needed to be acknowledged. DeDe not only expected and hoped that Steve would learn, but DeDe also hoped to learn from Steve.

The summer was unusually warm; the villagers were happy that the rain was not as torrential that year. Everyone enjoyed the chance to visit their kin without the need to use umbrellas or rain coats. Approximately one week after Steve arrived in the community, DeDe noticed that he was having difficulty understanding the Determinants of Health. Specifically, Steve was having trouble applying theory to practice. Steve could not understand that even though he was a nursing student on a First Nations reserve in Canada, poverty did exist, and in this case, this was devastating for all community members. Steve knew that nutrition, poverty, housing, education, accessibility to health care, and transportation all determined health; but he could not fathom that some people did not have a Grade 12 education, did not have a car, and did not speak English.

To help facilitate this gap in Steve's professional experience and to better link nursing theory to reality-based practice, DeDe asked the village Chief to ask three families in the village who experienced these obvious health deficits to each consent to one home visit. As well, she asked that the Chief access a village interpreter to interpret for the participating community members and the student. DeDe accompanied Steve on each of the three home visits. During each visit DeDe had Steve ask the family open-ended questions about how education, nutrition, poverty, transportation, and accessibility to health care determined not only the family's health, but the health of the community as well. At the end of the three visits Steve was asked to describe his feelings

about the three home visits, how theory linked with practice is fundamental to the practice of community health nursing, what communication skills were utilised, and what benefit he saw in the three home visits.

Construct Borderline, Related, Contrary, and Invented Cases

The sixth phase of concept analysis pertains to constructing a borderline, related, contrary, and invented case. An illegitimate case will not be constructed. A scrutiny of cases that are not exactly the same as the concept of interest but are similar to it, or contrary to it in some ways, helps to ascertain which defining characteristics have the best fit for preceptorship (Walker & Avant, 1995). The main purpose for the use of these cases is to help decide what does and does not count as defining attributes for preceptorship (Walker & Avant, 1995).

Borderline Cases

Borderline cases are those examples that contain some of the defining attributes of preceptorship, but not all of them.

DeDe was starting her new job today. She was excited because not only was she starting the job, but she also had just convocated with her master's in nursing (MN) degree. When she walked out of her office, she noticed a good friend walking down the hall. DeDe stopped Marge to talk and to briefly catch up. They talked for 15 minutes. Over the next three months DeDe began to realise that Marge had taken on a mentoring role towards her. Marge had her MN degree as well, they enjoyed each other's company, and had a similar sense of humour. DeDe appreciated and respected Marge's significant clinical experience and knowledge.

Related Cases

Related cases are examples of the concept, but they do not contain the defining attributes.

DeDe loved her new job as a clinical instructor. Today she had to teach a group of first-year nursing students how to take an oral temperature. The students had read the assigned literature and had practised on each other. First, DeDe had all the students gather in the demonstration lab and demonstrated the procedure for them. Then each of the students demonstrated the procedure on DeDe. After the skill demonstration, all of the students were encouraged to constructively critique the group's performance. Items discussed included the technique, the communication methods utilised, and client comfort.

Contrary Cases

Contrary cases are clear examples of what the concept is not (Walker & Avant, 1995).

DeDe was reading a transcultural-nursing article and was most intrigued by the content. Apparently, a third-year nursing student had gone to an isolated community in the Canadian Arctic for a community health nursing practicum. When the student arrived in the community to begin her three-month posting, she had not prepared her learning goals or objectives and she was sent home on the next scheduled plane.

Invented Cases

Invented cases are constructed using ideas outside our own experience (Walker & Avant, 1995).

Shannon gave DeDe an article describing a day in the life of an articling student of law. Knowing that DeDe was interested in law, Shannon felt that the article would be appreciated for the law student's unbelievable story.

Marcus had been at the law firm for two months and dearly hoped that the learning situation was going to improve significantly. He had not come to this law firm to pick up the laundry of the senior partner Mr. Zoob. Today Mr. Zoob asked Marcus to take his dog Poochy to the groomer. At the end of the day when Marcus was talking to his

two friends, who had accepted articling positions at two other larger law firms, they related the torts that they were writing and the courtroom preparation in which they were involved. Marcus was furious. What had he done to deserve this?

Identify Antecedents and Consequences

The identification of antecedents and consequences is the seventh step in the process of concept analysis. This step is often ignored in concept analysis (Walker & Avant, 1995). They are significant because they may illuminate the social contexts in which the concept is generally utilised.

Antecedents

Antecedents are events or incidents that must transpire prior to the occurrence of preceptorship:

1. enrolment in a nursing program,
2. preceptorship,
3. willingness of an organisation to accept a student nurse,
4. theoretical and clinical preparation of the student,
5. development of student learning objectives and goals,
6. syllabus preparation,
7. course preparation,
8. signing of a contract between the nursing program and the agency,
9. assignment of personnel from a nursing program to work with the preceptor and student, and
10. the student's need to meet requirements such as current cardiopulmonary resuscitation (CPR) and immunization certification.

Consequences

Consequences are those events or incidents that occur as a result of the occurrence of preceptorship. Consequences are also useful in "determining often neglected ideas, variables, or relationships that may yield fruitful new research directions" (Walker & Avant, 1995, p. 45).

1. bridging the theory-practice gap;
2. professionalization of nursing;
3. policy formation;
4. training of competent, confident, effective, efficient student nurses or new staff members;
5. socialisation of the student;
6. access of faculty personnel via student to agency;
7. legitimisation of the profession;
8. acknowledgement of preceptor's accomplishments;
9. acknowledgement of preceptors' accomplishments; and
10. entry of students into realms not otherwise available to them. For example, access to highly acute practice areas are not usually available to newly graduated nurses in areas such as the maternity ward, the intensive care unit, community health, emergency room, and cardiac care unit.

Define Empirical Referents

This is the final step in concept analysis. Walker and Avant (1995) stated that often the critical attributes and the empirical referents will be the same. Empirical referents are "classes or categories of actual phenomena that by their existence or presence demonstrate the occurrence of the concept itself" (Walker & Avant, 1995, p. 46). They are useful in practice because they provide clear, perceptible phenomena by

which to "diagnose" the existence of the concept in particular clients (Walker & Avant, 1995). The empirical referents for preceptorship include the following:

1. a one-to-one relationship or a two-to-one relationship (two students to one preceptor) (DeClute & Ladyshewsky, 1993),
2. a practicum,
3. a student and teacher,
4. a faculty member,
5. a program/course,
6. a grading/evaluation system, and
7. a care recipient; for example, patient, community.

Summary

The value of defining attributes and developing cases and identifying antecedents and consequences are:

1. clarifying the concept,
2. distilling the definition of preceptorship, and
3. describing the context around the concept.

CHAPTER VI

IDENTIFIED GAPS IN THE LITERATURE

As this thesis progressed, it became evident that there were identifiable gaps in the nursing literature in terms of the concept of preceptorship. Fundamental gaps in the literature occurred in the following areas: There was little literature pertaining to preceptorship in rural communities. How were rural or northern preceptors prepared? How were preceptees prepared for the very different cultural and clinical areas found in Northern Canada? What factors played a part in the successful completion of a northern preceptorship? What arrangement do faculties have to adequately prepare the preceptor and preceptee and themselves for a northern preceptorship?

Another gap in the nursing literature pertained to gender. Is the gender of a student nurse a factor in terms of the successful completion of a preceptorship? What, if anything, did gender have to do with preceptorship? Were there any unique defining characteristics that a male student possesses that contribute to a successful preceptorship?

Acknowledgement of preceptors was a factor in preceptorship on which nursing scholars have not come to a consensus. There appeared to be mixed feelings about what was appropriate in terms of acknowledging the preceptor. Whereas the preceptor appeared to prefer a written acknowledgement and a letter of reference, health care facilities appeared to prefer to give food rewards (e.g., luncheons, candy), pins, or articles of clothing.

What appeared to be missing in the nursing literature were clear definitions of mentor and mentorship. Some nursing articles tended to confuse these concepts with those of preceptor and preceptorship. If nursing scholars appear to be confused about these two different concepts, how can neophyte nurses gain a clear understanding about teaching and learning? When the profession of nursing has reached a consensus in terms

of the definition of the concept of preceptorship, the gap between theory and practice will have diminished.

Summary and Conclusions

The purpose of this study was to develop the concept of preceptorship through a theoretical analysis of the literature. It is anticipated that the result may assist nurses to understand the root meaning of the concept; the function of preceptorship; the need for one definition of the concept to provide clarity; how preceptors are acknowledged, supported, and prepared; the role of the faculty, the preceptor, and the preceptee; and the need for the preceptee to be provided with appropriate feedback, constructive criticism, and evaluation. As well, related concepts were explored, such as preceptorship programs, boundaries, and mentorship. The theoretical analysis of the literature involved a critical review of the research, theoretical and expert-opinion literature directly relating to the concept of preceptorship. Concepts and categories were drawn from the nursing, education, medicine, pharmacy, law, social work, rehabilitation, dentistry, and clinical psychology literature and explored to find common and dissimilar defining attributes related to preceptorship. The framework used to conduct the concept analysis was that of Walker and Avant (1995).

Common defining attributes found throughout the literature included being a role model, being a facilitator, having good communication skills, being knowledgeable about their field of expertise, needing to understand the principles of adult education, having the ability to give constructive feedback and give evaluations effectively to the preceptee, and being academically prepared. This researcher found that the three disciplines of nursing, medicine, and pharmacy have scholarly literature pertaining to preceptorship. The disciplines of social work, rehabilitation, and clinical psychology use similar concepts such as field education, clinical instructor, clinical supervisor, and clinical teacher. The concepts used by education and law are different from those previously

mentioned and include co-operating teacher, internship, mentoring relationship, associate teacher, master teacher, practicum advisor, teaching apprenticeships, and articling.

Although all of the aforementioned disciplines use concepts to address the teaching and learning of their students, there is not one discipline that uses just one concept to address teaching and learning of their students. The discipline of nursing appears to use the fewest concepts to address teaching and learning of the student; that concept is preceptorship. Even that concept appears to be confused with mentorship. Preceptorship represents a short-term relationship in which active teaching is involved, whereas mentorship is a longer-term relationship in which learning can still occur, but the basic knowledge has already been gained, usually in the preceptorship relationship.

Recommendations

With any research, there is an expectation that recommendations will be made based on findings or, in this case, based on an extensive multidisciplinary literature review. These recommendations will not be exhaustive, but will represent fundamental recommendations pertaining to preceptorship. The following areas will be discussed: preceptor preparation and function; definition; preceptor role as evaluator and facilitator; usefulness of the concept mentor; selection of preceptee; role of the faculty member; and the duty of the preceptor, preceptee, and faculty member to do no harm.

Preceptor preparation and function are key elements in terms of the preceptorship experience. The nursing literature is clear, and this researcher agrees that, regarding the need to have a preceptor academically prepared for the role, the preceptor should have at least 12 months of experience in the requisite nursing field and knowledge pertaining to the principles of adult education. In terms of function, the preceptor should act as a role model, be a facilitator for knowledge acquisition, and be the conduit through which the neophyte student or new employee will learn "What is a nurse?"

The definition of preceptorship that this researcher feels gives the best explanation and description of the concept is as follows:

> Involves access to an experienced and competent role model and a means of building a supportive one-to-one teaching and learning relationship. This relationship tends to be short-term [and is aimed at] assisting the newly qualified practitioner or nursing student to adjust to the nursing role. (Kaviani & Stillwell, 2000, p. 219)

The discipline of nursing needs one clear, well-defined definition of preceptorship to give focus and direction to nursing. Nursing is a practice discipline and preceptorship is the main method by which neophyte students and new employees learn the practice and art of nursing.

The preceptor's role as evaluator and facilitator is fundamental to the preceptorship experience. In terms of the role of evaluator, the preceptor must accept this role as a 'necessary evil.' This role is important to the preceptor, and the faculty member must also not abdicate his/her role as evaluator in the preceptorship process. The faculty member should do the final evaluation, with the preceptor's evaluation being used as part of the total evaluative process. In terms of the preceptor as facilitator, he/she should embrace the fact that what he/she does and says and role models will significantly impact the preceptee. The preceptor has certain expert knowledge pertaining to his/her area of nursing and therefore has easy access to clinical experiences from which the student will benefit. It is an expectation by the faculty member and the student that the preceptor will facilitate any and all learning opportunities for the student.

The selection of the preceptee for the preceptorship experience is just as important as the selection of the preceptor. The faculty member must know the preceptee well enough to be able to match the student to an appropriate placement based on the student's personality, academic ability, interpersonal skills, ethical skills, cultural skills, and maturity. This researcher recommends that all faculties of nursing develop a selection criteria tool that would successfully determine appropriate student placements. Although

this will not be an easy task, it can be done either through the use of existing tools or through the development of new, reliable, and valid tools.

The determination of the role of the faculty member is very important in the preceptorship experience. It is recommended that nursing faculties determine specific guidelines regarding the conduct of the faculty member, frequency of communication with both the preceptor and preceptee, and evaluation expectations for the preceptee by the faculty member.

The duty of the preceptor, preceptee, and faculty member is to do no harm towards the patient and/or community. It is imperative that the preceptee review the Nursing Code of Ethics and the Nursing Practice Standards prior to the commencement of the preceptorship experience.

Future Directions for Research: Questions to Ponder

The nursing literature is rife with articles relating to the evaluation of the student, but what about the evaluation of the preceptor and educational institution? Surely the timely and effective evaluation of the preceptor and the faculty member are equally important. Another possibility for future research pertains to the following: Has the discipline of nursing outgrown the term preceptor? Or is the term facilitator more appropriate? Does the concept of preceptor adequately address teaching and learning in the profession of nursing? Other salient topics for future research include the following: (a) How should preceptors be prepared? Should there be credentialing, or continuing education courses that are mandatory for the nurse to successfully pass prior to becoming a preceptor? Who would credential and teach these preceptor courses? (b) How can the nursing profession "do preceptorship better"? (c) How can the need for preceptor support by both faculty and the agency be explored? (d) How can tool development for preceptor selection be explored? How do you quantify the selection process and criteria for preceptorship? (e) Are students a benefit or a liability? For example, what makes a

student a liability and/or a benefit? There is a need to further explore this fascinating area and determine a cost/benefit analysis of student placement. Three articles (Bristow & Hagler, 1994, 1997; Hancock & Hagler, 1998) from the discipline of rehabilitation have already begun to explore this realm of teaching and learning; it is time for the nursing discipline to do the same. Is there any correlation between the student-preceptor ratio and the successful completion of a preceptorship? For example, would the student nurse have a greater chance of successfully completing a preceptorship if the student-preceptor ratio were 2:1 rather than 1:1? DeClute and Ladyshewsky (1993) contended that collaborative learning (student-preceptor ratio of 2:1) enhances the clinical education of physical therapy students.

All of the above gaps in the nursing literature lend themselves well to future research projects. Another question to ponder that may shed light upon teaching and learning in nursing is, "Where and when was the first article of preceptorship in nursing written, what discipline influenced the article, and who did they cite?"

DeDe could remember with fondness the first student she had preceptored before Steve. That student integrated well into the community, was culturally appropriate, had a great sense of humour, acted in a mature manner towards all members of the community, was very clinically competent, and listened to DeDe's suggestions regarding dress and what to bring to the community in terms of food and leisure activities. DeDe pondered why two students from the same secondary educational institution could be so different in terms of maturity, knowledge level, clinical preparedness, and personal conduct in the community. One thing was for certain: DeDe needed to learn more about preceptorship, especially in terms of her role and responsibility as a preceptor.

Wow! Steve could not believe the difficult practicum he had just completed. Why had the faculty picked DeDe to be my preceptor? Holy cow, was she ever demanding! Sure, I should have told her about the rape in the village, but to bust me for smoking a little weed with the rest of the guys, and on my own time? I can't understand why DeDe

got so bent out of shape. I am only 22 years old, and I need to have some fun. I never knew how hard it was to be a northern nurse. Even though DeDe was hard on me by making me learn how to suture, apply a cast, draw blood, do an immunization exam, do home visits on the elders, and fix the boiler at the nursing station, I do respect her knowledge and skills as a nurse. Maybe she had a point when she said that I needed to be more aware of culture and community health principles. I guess I was not very prepared for this posting. But why would it matter to her if I smoked some weed on my time off? I still don't understand.

Advantages and Limitations

The main advantage of concept analysis is that it renders very explicitly and theoretically operational definitions for use in nursing theory and research (Walker & Avant, 1995). Another advantage is that concept analysis can help clarify those terms in nursing that have become overused and hence have lost their meanings. A third advantage is its usefulness for tool development and nursing diagnosis. As well, the rigorousness of this intellectual exercise is extremely good practice in critical thinking. Conversely, the limitations are that the theorist must be painstaking and is likely to encounter problems that will impede the analysis. Walker and Avant (1995) advised that for concept analysis to occur, the researcher must have some sense of proportion, be willing to take risks, have a healthy sense of humour, and have a low anxiety level. Other limitations of this method include limitations by the available literature, time constraints of the researcher, and lack of common terminology and understanding between the different disciplines.

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